465 E High St, Suite 100 | Lexington, KY 40507 | 859-281-1166

HISTORY PROFILE

NAME ____________________________________ Date of Birth ___________ Today's Date_________

Any Issues With – current or past (√ if Yes):

___ Tonsils
___ Brain Part
___ Adenoids
___ Appendix
___ Gall Bladder
___ Spleen
___ Thyroid
___ Uterus
___ Ovaries
___ Kidney
___ Lung
___ Nerve Part
___ Stomach
___ Intestine
___ Thymus

	Right	Left
Arm, complete	___	___
Arm, below elbow	___	___
Hand	___	___
Part of Hand	___	___
Finger(s)	___	___
Shoulder	___	___
Leg, complete	___	___
Leg, below knee	___	___
Foot	___	___
Part of Foot	___	___
Toe(s)	___	___
Eye or Vision	___	___
Ear or Hearing	___	___
Facial Disfigurement	___	___
Bone Removal	___	___
Breast	___	___
Lymph Part	___	___
Spinal Part	___	___
Pelvic Part	___	___
Testicle	___	___

MEDICATIONS
(current or chronic)

___ Pain
___ Blood Pressure
___ Blood Thinner
___ Cholesterol
___ Kidney
___ Anti-Convulsant
___ Anti-Depressant
___ Anti-Psychotic
___ Cancer Drugs
___ Antibiotics
___ Steroids
___ Liver
___ Heart
___ Thyroid
___ Digestive
___ Diabetic
___ Birth Control
___ Parkinson's Meds

TOXIC EXPOSURES
(current or past)

___ Beauty Salon
___ Industrial
___ Asbestosis/Fiberglass
___ Heavy Metals
___ Radiation
___ Food Additives
___ Herbicide/Insecticide
___ Chlorine/Fluorine
___ Air/Water Pollution
___ Infectious Diseases

MAJOR DISEASES OR CONDITIONS
(past, present, or ongoing)

___ Circulation, Vascular, Arteries, Veins
___ Infections or History of Infections
___ Cancer, Tumors, Degenerative Diseases
___ Dietary or Absorption Disorder
___ Drug or Alcohol Addiction
___ Congenital or Inherited Birth Disorders
___ Allergies
___ Serious Trauma or Injury
___ Endocrine, Gland, or Hormone Disorder
___ Mental or Emotional Disorder
___ Sensory: Eyes, Ears, Taste, Feeling, Smell
___ Sensitivity to Humidity, Cold, Heat, Weather, etc.
___ Cognitive or Memory Disorders

HERITABLE DISORDERS

Mother ______________________________________
____
____

Father ______________________________________
____
____

TYPES OF STRESS
(Physical, Emotional, Relational, Work, Family, Illness, Etc.)

____
____
____

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LIFESTYLE QUESTIONS

Name: ____ Date: ____________________

Address: ____

City: ____________________________________ State: __________ Zip: _______ Country: ________________

Home Phone: ______________________ Cell: ____________________________ Fax: ___________________

Email: ____ Referred by: ________________________________

Date of Birth: M/____D/ ____Year/_______ Place of Birth: _______________________ Time of Birth: _________

***Do you have a Pacemaker? yes / no**

***Are you pregnant? yes / no**

*Are you sensitive to electricity? yes / no

*Rate how you feel today on scale of 1-10: _____

*Personal stress level (1-10 max.): _____

*Your positivity level (1 negative-10 positive): _____

If uncertain just answer as best you can.

Number of organs removed: _____

Number of prescription drugs currently used: _____

Amount you smoke/day: _____

Number of steroid type drugs used in last year: _____

Number of metal amalgam fillings-
(Current or present during last year): ______

Number of street drugs used in last month: _____

Number of known allergies: _____

Number of emotional mental factors: ______

(Depression, anger, anxiety, worry, etc.)

Responsibility for your health (1-10 max): _____

Amount of fat in diet (20-low,30-med,40-high): _____
(Include processed foods)

Vitamins taken daily ________, ________, ________,
_______, _______, _______, _______, _______, _______

Number of sugar type products/day: _____
(On average) Include soft drinks, ice cream etc.

Number of exercise sessions/week: _____
(15 minutes or more)

Number of alcoholic drinks weekly (average): ____

Number of cups of coffee, tea/day: _____
(Average caffeine intake)

Number of extreme toxic exposures: _____
(Radiation, insecticides, chemicals)

Number of major infections: ____
(Past and present)

Number of major injuries in past: _____
(Major car accidents, falls, etc.)

Number of glasses of water per day: _____

Are you comfortable with your weight? If not, how many lbs. over or under weight? _____