**Other Areas of Concern Health Questionnaire**

Client name: ___________________________ Date of Birth: _______________

What are your major concerns regarding your health?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

When did this problem begin? _____________________________________________

What seems to make it better? ____________________________________________

What seems to make it worse? _____________________________________________

Surgeries/Apx date:

*_____________________________

*_____________________________

*_____________________________

Dental history/Apx date:

*_____________________________

*_____________________________

*_____________________________

Describe your diet (Gluten-free, Paleo, Vegan, AIP, etc.)

________________________________________________________________________

________________________________________________________________________

Approximate date of any motor vehicle accidents or high impact falls (surfing, skateboarding, etc.)

*_____________________________ *_____________________________

*_____________________________ *_____________________________

*_____________________________ *_____________________________

Please indicate if any of these accidents resulted in whiplash (W), concussion (C), loss of consciousness (LOC), or other diagnosis (O)

Date of your last dental cleaning: ___________________________

Are you right or left or both hands dominate? ________________

What are your hobbies & sports?

______________________________________________________________________

______________________________________________________________________

What is your current career? ____________________________________________

Results of current lab results & dates:

| | |
|---|---|
| *____________________________ | *_____________________________ |
| *____________________________ | *_____________________________ |
| *____________________________ | *_____________________________ |

Medical History and Diagnosis. Check all that apply.

- ○ High Blood Pressure
- ○ Diabetes
- ○ Heart Disease
- ○ Cancer
- ○ Stroke
- ○ Neuropathy
- ○ Peripheral Vascular Disease
- ○ Osteopenia/Osteoporosis
- ○ Auto Immune (Lupus, Crohn's, MS, Fibromyalgia, etc.)
- ○ Other

Client Signature: Date:

______________________________________________________________________