Name_____ Date_____

Causes of Most Pain, Sickness and Disease

For your 1st visit-checkmark any causes you have experienced in last 6 months. For Re-exams-checkmark causes you are currently experiencing.

PHYSICAL

- __ Computer work hours per day _____
- __ Repetive stress activiites_____
- __ Over Exercise
- __ Under Exercise
- __ Poor Quality Sleep
- __ Sprains/strains_____
- __ Concussions
- __ Car Accidents (please list below)
- __ Falls (please list below)
- __ Sports injuries (please list below)
- __ Broken bones (please list below)
- __ Surgeries (please list below)
- __ Stitches
- __ Other_____

EMOTIONAL STRESSORS

- __ Work
- __ Home
- __ Negative thinker
- __ Divorce
- __ Death of a close family
- __ Job loss
- __ Diagnosed with disease
- __ Finacial stress
- __ Difficult childhood
- __ Family issues/conflict
- __ Hours watch T.V per day_____
- __ Guilt/ Remorse/ Regret
- Other_____

NUTRITIONAL TOXICITIES/ DEFIECIENCIES

- Eat white sugar
- Eat white flour
- Drink coffee
- Drink sodas
- Eat trans fats
- Eat fried foods
- Eat fast foods
- Overeating
- Stressed eating
- Undereating
- Other_____

CHEMICAL TOXICITIES

- __ Alcohol
- __ Vaccinations
- __ Toxic Cleaners
- __ Pesticides
- __ Fertilizers
- __ Work Place Chemicals
- __ Shower/ Swim in Chlorine Water
- __ Substance Abuse
- __ Prescription & Over the Counter Drugs (please list below)

List all recent accidents, falls, & injuries within the last 6 months:

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		

List accidents, falls & injuries (physical traumas) BEFORE 6 months ago:

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		

List all hospitalizations, surgeries, broken bones, stiches etc:

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		

List all current prescribed medications:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

List all current "over the counter" medications:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____