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Core Restore Health History Report for Existing Clients

PRINT CLEARLY PLEASE

Name: ______________________________Phone: _______________Cell: ___________

Complete Address: ____

Email: ____

Gender: ________DOB: ______ Age ____Emergency Contact #: ____________________

1. Have you ever had? (Please check the ones that apply to you)

- High blood pressure_____
- Heart or circulation disorders_____
- Seizures______
- Dizzy spells_____
- Diabetes_____
- Degeneration Joint Disease ______
- Arthritis/Osteoarthritis_____
- Scoliosis_____
- Kyphosis_____
- Osteoporosis_____
- Auto Immune Deficiency Disease_____
- Asthma_____
- Direct Injuries/Trauma to Head/Neck_____
- Joint swelling/stiffness_____
- Multiple Sclerosis_____
- Epilepsy/Seizure Disorder_____
- Cancer/Tumors_______
- Chronic Fatigue Syndrome_____
- Fibromyalgia_____
- Thyroid Condition_____
- High Cholesterol___/____
- Recent Infections_____
- Neuropathy____ Location_______
- Smoking History__________
- Back or Neck Problems________
- Car Accidents/Whiplash_____
- Headaches_____
- Average Hours Sleep per Night_____ #of hours
- Other______________________

2. In regards to your health, has anything changed significantly from your last MAT visit medications, health history, diet changes, exercise changes, surgeries/injuries, etc. If so please list or describe:

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