SOCIAL HISTORY

Does income meet monthly expenses? Yes No
Are you currently married? ___ divorced? ___ number of children? _____
Have you traveled outside the U.S. in the past year? Yes No Where? _____
Military Status: When did you serve? Where? _____
Discharge Status _____

PERSONAL CARE

Which of the following do you use on a regular basis

☐ Toothbrush 1/2/3 x/day	☐ Flossing	☐ Elect. Hair dryer/Blanket	☐ Hair Spray
☐ Shower	☐ Hot/Cold Baths	☐ Steam	☐ Sauna
☐ Dry brushing of skin	☐ Mineral Bath	☐ Enemas	☐ Colonic Irrigation
☐ Oils	☐ Deodorant	☐ Cosmetics	☐ Clay Packs

What type of clothing do you wear?

☐ Cotton	☐ Wool	☐ Synthetic	☐ Dyed

Are you intolerant to tight fighting clothes or neck ties? Yes No

Home environment & other Environmental exposures

Which of the following do you routinely use at home?

☐ Electric Heat	☐ Radiant Heat	☐ Gas Heat	☐ Oil Heat
☐ Wood Stove	☐ Forced air	☐ Air Conditioning	☐
☐ Electric Blanket	☐ Feather Pillow	☐ Heated Waterbed	☐
☐ Computer screen	☐ TV	☐ Microwave	☐

Other (specify)_____

Type of water

☐ Filtered	☐ Spring	☐ Well
☐ Deionized	☐ Distilled Water	☐ Tap

Is your home and/or work environments well ventilated? Yes No
Is your home or work environments excessively? Damp Moist
Are there unusual/unpleasant smells in your work/living environment? Yes No
When were the ducts in your home last cleaned_____

Which of the following are most enjoyable or bothersome to you? Circle B for better , W for worse

Summer? B W	Winter? B W	Fall? B W	Spring? B W
Sunshine? B W	Lack of sunshine? B W	New Moon? B W	Full Moon? B W
Dampness? B W	Dryness? B W	Heat? B W	Cold? B W
Seashore? B W	Mountains? B W	Approach of storms? B W	Change in weather? B W
Wind? B W	Poor air ventilation? B W	Fluorescent lighting ? B W	Traveling? B W
Morning? B W	Afternoon? B W	Evening? B W	Night? B W

Which of the following are known allergies?

☐ Dust	☐ Mold	☐ Grasses/weeds	☐ Tree pollens
☐ Car fumes	☐ Perfume	☐ Tobacco smoke	☐
☐ Dogs	☐ Cats		☐

PERSONAL HISTORY

For the following sections, please circle "Y" for yes or "N" for no.

Childhood Illnesses

Measles	Y N	Chicken pox	Y N	Rheumatic fever	Y N
Mumps	Y N	Diphtheria	Y N	Whooping cough	Y N
Rubella	Y N	Scarlet fever	Y N	Other _____	

Immunizations

Diphtheria	Y N	Measles /Mumps /Rubella	Y N
Pertussis	Y N	Polio	Y N
Tetanus shot	Y N	Other _____	

Do you have any contagious diseases at this time? Y N
If yes, what? _____

Hospitalization and Surgery

What hospitalizations, surgeries, or blood transfusions have you had?

_____

_____

X-rays and Special Studies

Besides dental care, what X-rays, CAT scans, or other studies you have had and why?:

_____

_____