List any major disease or illness in your immediate family and indicate family member:

____

____

List all medications or supplements, including herbs and vitamins you are currently taking:

____

____

Occupation:____

Do you have a regular exercise program? ___________ Please describe. ________________________

____

____

Are you on a restricted diet? ______________________ What kind? ___________________________

How much sugar/dessert do you eat per week?

____

How much dairy do you eat per week?

____

How many packs of cigarettes do you smoke per week?

____

How much coffee, tea, or cola do you drink per week?

____

How much alcohol do you drink per week?

____

Do you do any drugs? How much per week?

____

Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).