

How would you rate your health? Excellent Good Fair Poor

Do you wear: Dentures Contact Lenses Prosthesis

Do you eat a balanced diet? _____

How much water do you drink each day? (Recommended consumption is ½ your body weight in ounces) _____

Do you have any history of muscular or skeletal disease or injury? _____

If yes, please specify: _____

Please circle any of the following conditions that apply to you:					
Abdominal Pain	Chronic Fatigue				
Fibromyalgia	Allergies	Carpal Tunnel Syndrome	Whiplash	Depression	Heart Disease
High Blood Pressure	Low Blood Pressure	Diabetes	Arthritis	Migraine Headaches	
Sinusitis or Sinus Problems	Breast Augmentation or Reduction		Spinal Problems	Varicose Veins	

Please use this body map to indicate with an "X" or by Circling the areas which are causing you discomfort. Feel free to make notes in the margins.

