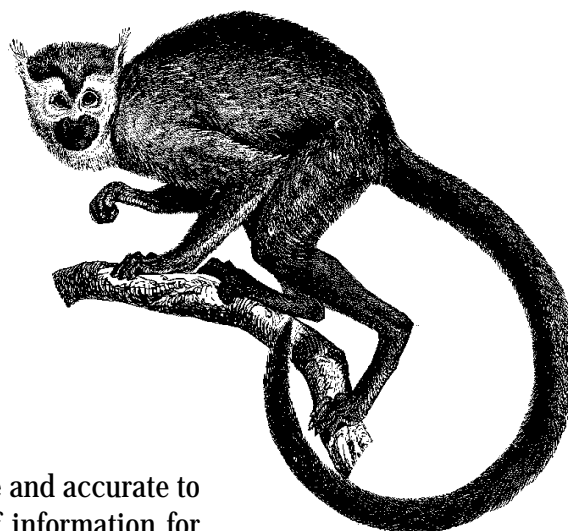


<u>Past</u>	<u>Current</u>	<u>Health Conditions</u>	<u>Past</u>	<u>Current</u>	<u>Dental</u>	<u>Yes</u>	<u>No</u>	<u>Unknown</u>	<u>Birth</u>
___	___	Heart Condition	___	___	Braces	___	___	___	Drugged Mother
___	___	Varicose Veins	___	___	Retainer	___	___	___	Mother had an Epidural
___	___	Blood Clots	___	___	Root Canals	___	___	___	Forceps Delivery
___	___	High Blood Pressure	___	___	Extractions	___	___	___	Breech Presentation
___	___	Low Blood Pressure	___	___	Crowns	___	___	___	Prolonged Labor
___	___	Breathing Difficulty	___	___	Bridges	___	___	___	Premature
___	___	Herpes	___	___	Dentures	___	___	___	Late
___	___	Fatigue							
___	___	Sleep Disorders							
___	___	Numbness/Tingling							
___	___	Chronic Pain							
___	___	Rashes							
___	___	Scars							
___	___	Allergies							
___	___	Sinusitis							
___	___	Melanoma							
___	___	Cancer							
___	___	Diabetes							
___	___	Immune System Disorders							
___	___	Eating Disorders							
___	___	Depression							
___	___	Recreational Drug Use							
___	___	Alcohol Use							
___	___	Nicotine Use							
___	___	Sugar Use							
___	___	Caffeine Use							
___	___	Vision Impairment							
___	___	Hearing Impairment							
___	___	Pregnancy							
___	___	Severe Menstrual Cramping							
___	___	Excessive Menstruation							
___	___	Lack of Periods							
___	___	Intense PMS							
___	___	Endometriosis							

Anything else you want me to know...



Please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for medical or insurance purposes. I authorize Todd A. Jackson, LMT to exchange information with my primary health care providers in order to ensure that I receive the most beneficial treatment possible. I understand that Todd neither diagnoses nor prescribes. I agree to pay for appointments canceled with less than 24 hours notice.

Date: _____

Signature