"Since 1982"
CRUZ Life CENTER

Natural Health Care Solutions for Your Life

- LASER THERAPY
- CHIROPRACTIC
- HEALTH COACHING

Confidential Health History

Please Print Clearly

Name: _____

Address: _____

Email Address: _____ How often do check email?_____

Telephone Numbers Work:_____Home:_____Cell:_____

Age: _____ Height:_____ Date of Birth:_____ Place of Birth:_____

Current Weight:_____ Weight six months ago:_____ One year ago:_____

Would you like your weight to be different?_____ If so, what?_____

Occupation:_____ Hours of work per week:_____

Do you sleep well?_____ Do you wake up at night?_____ What times?_____

To urinate?_____ What time do you generally get up in the morning?_____

Constipation/ Diarrhea?_____ Explain:_____

What blood type are you?_____ What is your ancestry?_____

Women: Are your periods regular? _____How many days is the flow?_____How frequent?_____

Painful or symptomatic?_____ Please explain:_____

Are there any healers, helpers, or therapies with which you are involved? _____

What role does exercise play in your life? _____

Do you have warts, athletes foot, toe fungus, psoriasis or any viruses/infections? _____

Do you drink, alcohol, coffee, sodas, smoke, or have any addictions?_____

What percentage of your food is home cooked?_____Where do you get the rest of it?_____

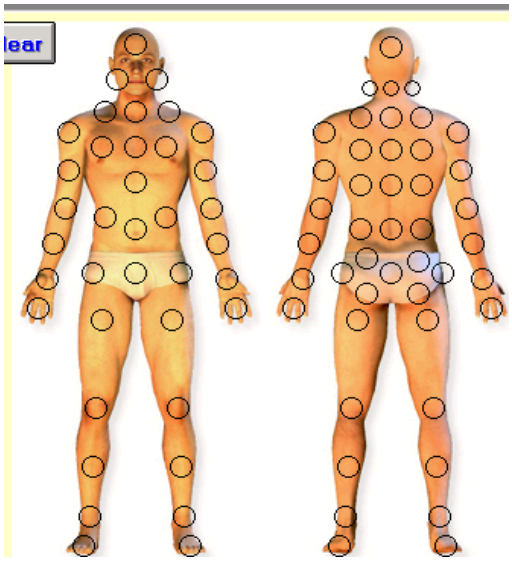
Serious illness/ hospitalizations / injuries? _____

What are your goals for this visit?_____

What is your energy level on scale of 1 – 10: _____What do you do to increase your energy?

_____

Please indicate on chart where you are experiencing pain:



☐You ☐Parent	Heart disease or stroke	☐You ☐Parent	Food Allergies
☐You ☐Parent	High blood pressure	☐You ☐Parent	Neuromuscular disease
☐You ☐Parent	High triglycerides	☐You ☐Parent	Arteriosclerosis
☐You ☐Parent	Cancer	☐You ☐Parent	Gall bladder disease
☐You ☐Parent	Lung/ pulmonary disease	☐You ☐Parent	Diabetes mellitus
☐You ☐Parent	Kidney disorder	☐You ☐Parent	Anorexia / Bulimia
☐You ☐Parent	Osteoporosis	☐You ☐Parent	Compulsive overeating
☐You ☐Parent	Ulcer	☐You ☐Parent	Anemia
☐You ☐Parent	Gastrointestinal disease	☐You ☐Parent	Arthritis
☐You ☐Parent	Diarrhea / Constipation	☐You ☐Parent	Alcohol Abuse
☐You ☐Parent	Depression / Anxiety	☐You ☐Parent	Addictive Habits
☐You ☐Parent	Weight issues	☐You ☐Parent	Mental Health Issues

Please list all types of medications / supplements you take & for what reason.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list what you have eaten or drank in the last two days.

_____

_____

_____

_____