new life
CHIROPRACTIC
&
REGENERATIVE MEDICINE

Regenerative Therapy

Health Questionnaire

Please fill out the following health questionnaire prior to your treatment. This information will help us serve you better.

Name:_____ Date of Birth:_____

Any known medication allergies: Yes No

Names of medications and your reaction:

Have you ever been diagnosed with cancer? Yes No

If yes, what site and what year?

To your knowledge, are you cancer free currently? Yes No

Do you take any blood thinners? Yes No

If yes, what medication, dose, and reason for taking:

Have you had any *unintentional* weight loss in the last 6 months of greater than 10 pounds? Yes No

Do you take any Non-steroidal anti-inflammatory medications? (examples: Motrin, Ibuprofen, Celebrex, Meloxicam, Aleve, Aspirin) Yes No

If yes, list medication, dose, and frequency.

Have you had a steroid injection or oral steroids for any purpose in the last 3 months? Yes No

Please list all medications you take, along with the dose, frequency, and purpose:

Medications	**Dose**	**Frequency**	**Purpose**

Print Name_____

Signature_____ Date _____

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