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## Medical History (Check All That Apply) Initial Evaluation Form

□ Sleep a □ Depress □ Arthritis □ Migrain □ Cancer □ Diabete □ Other _	ion/anxiety e/headaches s	
☐ Thyroid☐ Asthma	problems	
	Frequency:	
3	Depress Arthritis Migraine Cancer Diabete Other  Thyroid Asthma Other  Other  Yes	□ Sleep apnea □ Depression/anxiety □ Arthritis □ Migraine/headaches □ Cancer □ Diabetes □ Other □ Thyroid problems □ Asthma □ Other □ Yes □ No Type: □ Frequency: □ Yes □ No