



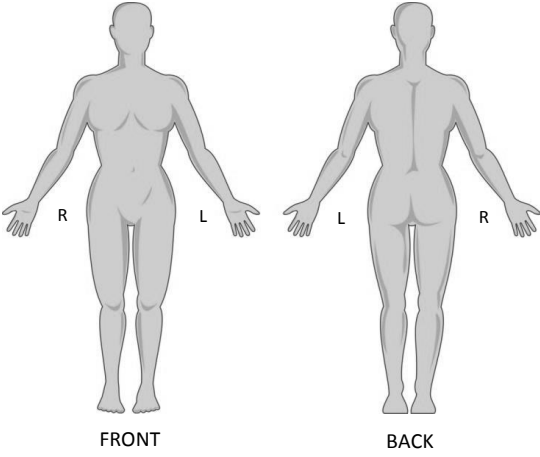
NEURAL HEALTH HISTORY

JACKIE BELL NATURAL HEALTH

Name _____

Age _____

Date _____

SURGERIES		AGE	SERIOUS INFECTIOUS DISEASES (pneumonia, bronchitis, mono, TB, cancer, heart attack, colitis, mumps, measles, chicken pox, etc.)		AGE	Put an X where you have pain or dysfunction. 
_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	
			TYPICAL CHILDHOOD VACCINATIONS? Yes ___ No ___			
INJURIES/ACCIDENTS WITH STITCHES		AGE	LONG PERIODS ON PRESCRIPTION/STREET DRUGS, ALCOHOL, OR CIGARETTES		AGE	
_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	
INJURIES/ACCIDENTS WITHOUT STITCHES		AGE				PREGNANCIES/BIRTHS/ABORTIONS/ IUDs, BIRTH CONTROL, etc.
_____	_____	_____	_____	_____	_____	AGE
_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	
LONG VISITS OR LIVED IN A FOREIGN COUNTRY (INDIA, MEXICO, AFRICA, ETC.)		AGE	TOXIC PROFESSION PAST OR PRESENT (artist, dentist, dental assistant, painter, mechanic, industrial worker, cleaner, etc.)		AGE	MAJOR PSYCHOLOGICAL TRAUMA
_____	_____	_____	_____	_____	_____	AGE
_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	
TREATED FOR PARASITES/INFECTION? Yes ___ No ___			_____	_____	_____	



NEURAL HEALTH HISTORY

JACKIE BELL NATURAL HEALTH

Name _____

Date _____

HEALTH COMPLAINTS	AGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DENTAL INTERVENTION	
(Age of first silver metal filling, braces, retainers, root canals, and extractions. For tooth numbers, see Dental Chart.)	AGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DENTAL KEY

Place the markings on the chart as accurately as you can.

- Pulled Teeth X
- Teeth that did not grow in ✓
- Filled cavities ●
- Crowns ■
- Bridge —
- Root Canal ○

Braces Upper _____ Lower _____

Retainer/Night Guard Upper _____ Lower _____

Dentures Upper _____ Lower _____

Do you have metal amalgam fillings? Yes _____ No _____

If you had any metal amalgam fillings in the past, were they removed safely? Yes _____ No _____ Not sure _____

DENTAL CHART

RIGHT/LEFT means **YOUR** RIGHT/LEFT. Teeth #1, #16, #17, and #32 are your wisdom teeth.

