HEAD - (CIRCLE AS MANY AS APPLY)

Lightheaded Fainting Loss Of Balance Memory Loss
Double Vision Blurred Vision Light Sensitivity Bloodshot Eyes
Hearing Loss Ringing In Ears Head Feels Heavy
HEADACHE: Migraine Tension Pressure Throbbing Sinus
Daily 1XWeek 2XWeek 3XWeek ___XWeek ___XMonth
Back Of Head Forehead Temples Behind Eyes All Over
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

NECK - (CIRCLE AS MANY AS APPLY)

Pain Stiff Tight Tension Ache
Left Side Right Side Both Sides
Base of Skull Nape of Neck Entire Neck
Muscle Spasms Muscle Weakness Grinding/Grating
Aggravated by: Forward Movement Backward Movement
Rotate Left Rotate Right
Bend Left Bend Right
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

SHOULDERS - (CIRCLE AS MANY AS APPLY)

Pain Across Shoulders	Left	Right	Both
Pain In Joint	Left	Right	Both
Limitation Of Motion	Left	Right	Both

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

ARMS & HANDS - (CIRCLE AS MANY AS APPLY)

Pain In:	Upper Arm	Left	Right	Both
	Elbow	Left	Right	Both
	Forearm	Left	Right	Both
	Wrist	Left	Right	Both
	Hand	Left	Right	Both
Pins & Needles In:	Arm	Left	Right	Both
	Hand	Left	Right	Both
Numbness In:	Arm	Left	Right	Both
	Hand	Left	Right	Both

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

MID BACK - (CIRCLE AS MANY AS APPLY)

Pain	Left	Right	Center
Spasms	Left	Right	Center
Tension	Left	Right	Center

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

CHEST - (CIRCLE AS MANY AS APPLY)

Pain Between Ribs	Left	Right	Both
Pain in Breast Bone	Left	Right	Both

Shortness Of Breath Irregular Heartbeat
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

ABDOMEN - (CIRCLE AS MANY AS APPLY)

Constipation Indigestion Nausea
Diarrhea Heartburn Gas
Loss Of Appetite Nervous Stomach Pain
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

LOW BACK - (CIRCLE AS MANY AS APPLY)

Low Back Pain	Left	Right	Both
Sacroiliac Pain	Left	Right	Both
Buttock Pain	Left	Right	Both
Hip Pain	Left	Right	Both

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

LEGS & FEET - (CIRCLE AS MANY AS APPLY)

Pain Radiates Down Leg to:	Mid-Thigh	Left	Right	Both
	Knee	Left	Right	Both
	Calf	Left	Right	Both
	Foot	Left	Right	Both
Pins & Needles In:	Leg	Left	Right	Both
	Foot	Left	Right	Both
Numbness In:	Leg	Left	Right	Both
	Foot	Left	Right	Both

Ankle Pain Swollen Ankle Foot Pain Swollen Feet Cramps
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

OTHER - (CIRCLE AS MANY AS APPLY)

Anxiety Nervousness Irritability Apprehension
Disturbed Sleep Fatigue Depression Inability to Concentrate
Jaw Pain Hemorrhoids Ulcers Cancre Sores
Frequent Urination Painful Urination Incontinence
Difficulty Starting Urinary Flow Difficulty Holding Urine
Heart Trouble Recurrent Infections Prostate Trouble
Menstrual Pain Menstrual Irregularity Hot Flashes PMS
Frequent Colds Asthma Allergies Chronic Cough
Weight Loss Weight Gain Hypoglycemia Diabetes
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Comments:_____

CHECK ANY of the following conditions YOU NOW HAVE

METABOLIC
- ____ Heart Disease
- ____ Cancer
- ____ Stroke
- ____ Arthritis
- ____ Neuritis
- ____ Colitis

DIGESTIVE
- ____ Irritable Bowel
- ____ Belching
- ____ Flatulence
- ____ Vomiting
- ____ Blood in Stool
- ____ Food Sensitivities

EYES - EARS - NOSE - THROAT
- ____ Glasses
- ____ Floaters
- ____ Loud Noise Intolerable
- ____ Dry Nasal Membranes
- ____ Excess Mucous
- ____ Hoarseness

OTHER:_____

_____

I understand that the information provided above will assist the doctor in making clincal decisions and acknowledge that these records and any tests performed, including x-rays, will remain a part of my permanent record. I have answered every question fully and completely.

SIGNATURE of PATIENT/GUARDIAN_____