

<p>HEAD</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <ul style="list-style-type: none"> <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sinus or allergy <input type="checkbox"/> Entire head <input type="checkbox"/> Back of Head <input type="checkbox"/> Forehead <input type="checkbox"/> Temples <input type="checkbox"/> Migraine <input type="checkbox"/> Head feels heavy <input type="checkbox"/> Loss of vision <input type="checkbox"/> Buzzing in ears <input type="checkbox"/> Loss of memory <input type="checkbox"/> Loss of taste <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Light headedness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Double vision <input type="checkbox"/> Pain in ears 	<p>MIDBACK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Dull ache Location _____ <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Pain between shoulder blades 	<p>CHEST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Pain around ribs <input type="checkbox"/> Breast pain <input type="checkbox"/> Irregular heartbeat
<p>NECK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in neck <ul style="list-style-type: none"> <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Pain with movement <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn to left <input type="checkbox"/> Turn to right <input type="checkbox"/> Bend to left <input type="checkbox"/> Bend to right <input type="checkbox"/> Grinding sounds in neck <input type="checkbox"/> Popping sounds in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Arthritis in neck 	<p>LOW BACK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low back pain <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes Location _____ <input type="checkbox"/> Sacroiliac joint (R) (L) Low back pain is worse when: <ul style="list-style-type: none"> <input type="checkbox"/> Working <input type="checkbox"/> Standing <input type="checkbox"/> Lifting <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Stooping <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Pain relieved when _____ <input type="checkbox"/> Bulging disk level _____ <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Arthritis 	<p>WOMEN ONLY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Menstrual pain _____ (where) <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity <input type="checkbox"/> Cycle _____ Days <input type="checkbox"/> Birth control _____ (Type) <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Genital cancer _____ <input type="checkbox"/> Discharge <input type="checkbox"/> Menopause <input type="checkbox"/> Abortions <input type="checkbox"/> Are you or do you think you are pregnant? _____
<p>SHOULDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in shoulder joint (R) (L) <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Bursitis (R) (L) <input type="checkbox"/> Arthritis (R) (L) <input type="checkbox"/> Can't raise arm (R) (L) <ul style="list-style-type: none"> <input type="checkbox"/> Above shoulder level <input type="checkbox"/> Over head <input type="checkbox"/> Tension in shoulder (R) (L) <input type="checkbox"/> Pinched nerve in shoulder (R) (L) <input type="checkbox"/> Muscle spasm in shoulder (R) (L) 	<p>ARMS & HANDS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in upper arm (R) (L) <input type="checkbox"/> Pain in forearm (R) (L) <input type="checkbox"/> Pins & needles in arm (R) (L) <input type="checkbox"/> Pain in elbow (R) (L) <input type="checkbox"/> Aggravated by _____ <input type="checkbox"/> Pain in hands (R) (L) <input type="checkbox"/> Hands cold (R) (L) <input type="checkbox"/> Pain in fingers (R) (L) <input type="checkbox"/> Pins & needles in fingers (R) (L) <input type="checkbox"/> Arthritis in fingers <input type="checkbox"/> Fingers fall asleep <input type="checkbox"/> Numbness in fingers (R) (L) <input type="checkbox"/> Sore joints in fingers <input type="checkbox"/> Swollen joints in fingers (R) (L) <input type="checkbox"/> Numbness in fingers <input type="checkbox"/> Loss of grip strength 	<p>MEN ONLY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Night urination <input type="checkbox"/> Prostate pain/swelling
<p>ABDOMEN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervous stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Foods can't eat _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids 	<p>HIPS, LEGS & FEET</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Pain in buttocks (R) (L) <input type="checkbox"/> Knee pain (R) (L) <ul style="list-style-type: none"> <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Pain in hip joint (R) (L) <input type="checkbox"/> Pain down leg (R) (L) <input type="checkbox"/> Leg cramping (R) (L) <input type="checkbox"/> Numbness of leg (R) (L) <input type="checkbox"/> Pins & needles in legs (R) (L) <input type="checkbox"/> Swollen ankles (R) (L) <input type="checkbox"/> Feet feel cold (R) (L) <input type="checkbox"/> Cramps in feet (R) (L) <input type="checkbox"/> Numbness of feet (R) (L) <input type="checkbox"/> Swollen feet (R) (L) <input type="checkbox"/> Numbness of toes 	<p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervousness <input type="checkbox"/> Depressed <input type="checkbox"/> Fatigue <input type="checkbox"/> Generally rundown <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Irritable <input type="checkbox"/> Normal sleep _____ hrs. /night <input type="checkbox"/> Loss of sleep _____ hrs. /night <input type="checkbox"/> Gain/loss of weight _____ lbs. <input type="checkbox"/> Coffee _____ cups/day <input type="checkbox"/> Tea _____ cups/day <input type="checkbox"/> Cigarettes _____ pack/day <input type="checkbox"/> Diabetes type _____ <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Heart problems _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Lung disease _____ <input type="checkbox"/> Tumors _____ <input type="checkbox"/> Cysts _____ <input type="checkbox"/> Auto accidents: when _____ <input type="checkbox"/> Work injuries: when _____ Describe _____ _____ _____ _____ <input type="checkbox"/> Other injuries/health problems _____ _____ _____

Print Name: _____

Signature: _____ Date: _____