

For each of the symptoms or conditions below, place a check next to the symptoms or conditions that you currently have.

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| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Enlarged Glands |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Spitting up Blood |
| <input type="checkbox"/> Elbow Pain / Arm Pain | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Spitting up Phlegm |
| <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Angina | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Dermatitis / Eczema / Rash |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Knee / Leg pain | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Ankle / Foot Pain | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Joint Swelling / Stiffness | <input type="checkbox"/> Inability to Urinate | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Nervousness / Depression |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Smoking / Use of Tobacco |
| <input type="checkbox"/> General Fatigue | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Drug or Alcohol Dependence |
| <input type="checkbox"/> Decrease Quality of Sleep | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Loss of Appetite | |
| <input type="checkbox"/> Changes in Vision | <input type="checkbox"/> Loss of Weight | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hernia | Females only |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Are you Pregnant |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cramps or Backache |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive Menstrual Flow |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Irregular Cycle |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Liver / Gall Bladder Problems | <input type="checkbox"/> Painful Menstruation |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Menopausal Symptoms |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Changes in Hearing | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hormone Replacement |

Indicate if an immediate family member has had any of the following

Arthritis Heart Problems Stroke Diabetes Cancer other _____

List any Hospitalizations or Surgical Procedures _____

List any medications that you are taking _____

Have you ever been in an auto accident _____ describe injuries _____

List any injuries where you were knocked unconscious, fractured a bone, or had any type of injury _____

List any other information you feel is important _____

I realize that I am responsible for any copayments and deductibles for all covered services and any noncovered services my insurance does not cover. I understand any outstanding balances may have interest charged. Please ask if you have any questions.

Patient Signature _____ Date _____