



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

- |   |  |   |
|---|--|---|
| <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 \_\_\_\_\_