

Please check (x) all present symptoms.

<p>HEAD: <input type="checkbox"/> Headache <input type="checkbox"/> Sinus <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"/> Loss of memory <input type="checkbox"/> Light-headed <input type="checkbox"/> Fainting <input type="checkbox"/> Light bothers eyes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Loss of balance <input type="checkbox"/> Loss of taste <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Dizziness <input type="checkbox"/> Pain in ears <input type="checkbox"/> Ringing or noises in ears</p> <p>NECK: <input type="checkbox"/> Pain in neck <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Ache <input type="checkbox"/> Neck pain with movement <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turning (L) (R) <input type="checkbox"/> Bending (L) (R) <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding sounds in neck <input type="checkbox"/> Popping sounds in neck</p> <p>SHOULDERS: <input type="checkbox"/> Pain in joint (L) (R) <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Arthritis (L) (R) <input type="checkbox"/> Can't raise arm <input type="checkbox"/> Above shoulder level <input type="checkbox"/> Over head <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Pinched nerve in shoulder (L) (R) <input type="checkbox"/> Muscle spasms in shoulder</p> <p>ARMS AND HANDS: <input type="checkbox"/> Pain in arm <input type="checkbox"/> Tennis elbow <input type="checkbox"/> Pain in hands/fingers (L) (R)</p>	<p><input type="checkbox"/> Pins and needles sensation (L)(R) <input type="checkbox"/> Numbness (L) (R) <input type="checkbox"/> Hands cold <input type="checkbox"/> Loss of grip strength <input type="checkbox"/> Sore/swollen joints in fingers</p> <p>MIDBACK: <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Sharp stabbing <input type="checkbox"/> Dull ache <input type="checkbox"/> Muscle spasms</p> <p>CHEST: <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Rib pain <input type="checkbox"/> Breast pain <input type="checkbox"/> Irregular heartbeat</p> <p>ABDOMEN: <input type="checkbox"/> Nervous stomach <input type="checkbox"/> Foods can't eat _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids</p> <p>LOW BACK: <input type="checkbox"/> Lower back pain <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Ache</p> <p>Location: <input type="checkbox"/> Upper lumbar <input type="checkbox"/> Lower lumbar <input type="checkbox"/> Hip <input type="checkbox"/> Low back pain is worse when <input type="checkbox"/> Working <input type="checkbox"/> Lifting <input type="checkbox"/> Stooping <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Lying down <input type="checkbox"/> Walking <input type="checkbox"/> Pain relieved when _____ <input type="checkbox"/> Slipped disc <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms</p>	<p>HIPS, LEGS & FEET: <input type="checkbox"/> Pain in buttocks (L) (R) <input type="checkbox"/> Pain in hip joint (L) (R) <input type="checkbox"/> Pain down leg (L) (R) <input type="checkbox"/> Knee pain (L) (R) <input type="checkbox"/> Outside <input type="checkbox"/> Inside <input type="checkbox"/> Leg cramps <input type="checkbox"/> Feet cramps <input type="checkbox"/> Pins and needles in legs <input type="checkbox"/> Numbness in legs/feet <input type="checkbox"/> Swelling in legs/feet</p> <p>WOMEN ONLY: <input type="checkbox"/> Menstrual pain <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"/> Tumors/Cancer _____ <input type="checkbox"/> Discharge <input type="checkbox"/> Menopause <input type="checkbox"/> Abortions <input type="checkbox"/> Are you pregnant</p> <p>MEN ONLY: <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Difficulty urination <input type="checkbox"/> Night urination <input type="checkbox"/> Prostate swelling</p> <p>GENERAL: <input type="checkbox"/> Nervousness <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Fatigue <input type="checkbox"/> Run-down feeling <input type="checkbox"/> Normal sleep _____ hrs <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight _____ lbs <input type="checkbox"/> Weight gain _____ lbs <input type="checkbox"/> Coffee _____ cups/day <input type="checkbox"/> Tea _____ cups/day <input type="checkbox"/> Cigarettes _____ pack/day <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia</p> <p>OTHER: _____ _____ _____</p> <p>MEDICATIONS: _____ _____ _____</p>
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Signature: _____

Date: _____