

HEALTH CONCERNS: Please list your top health concerns in order of priority.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
- I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
- I am looking to take care of my problem and then go on to "achieve optimal health and wellness".

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: Y N
 If yes, whom? _____ Treatment(s): _____
 Have you had any intolerance or reactions to treatments? Y N Describe: _____
 If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____ Has it become worse recently? Y N Same Better Gradually worse
 How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day Few hours Minutes
 Is this condition interfering with your: Work Sleep Daily Routine Recreation Other: _____
 How long has it been since you really felt good? Days Weeks Months Years >10 years
 Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____
 What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____
 Is there anything that you can do to relieve the problem? Y N If yes, describe _____
 If no, what have you tried to do that has not helped? _____
 What do you think is wrong with you? _____
 Are there any other conditions or symptoms that may be related to your major symptoms Y N If yes, what? _____
 Have you been in any automobile accidents? Past year Past five years Over five years Never
 Describe: _____

Please check all of the symptoms that apply. (P=Past / C=Current)

- | P / C | P / C | P / C |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Elbow/Hand Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Feel Loss of Control |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Low Back Pain | |
| <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Hip Pain | |
| <input type="checkbox"/> Unsteady Voice | <input type="checkbox"/> Knee Pain | |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Swollen Joints | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Joint Stiffness | |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Swollen Ankles | |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Ankle/Foot Pain | |

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

- Stabbing/cutting - ||| Tingling - ...
- Burning - XXX Cramping - ^^^
- Numbness - === Dull - ###

