

If you have ever had a symptom listed below in the past, please check the PAST column. If you are presently troubled by a particular symptom, check the PRESENT column.

PAST	PRESENT		PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm/Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg/Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg/Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Rash/Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	Please Check Any That Apply to You:		
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Ringing)	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains			_____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			_____
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
		<input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Procedures (please list)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			_____
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic General Body Pain	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated drinks (cups per day _____)

Do you have a permanent disability rating? Yes No Body Part _____
 Date you received disability rating: ____/____/____ Disability Percentage: _____%

Present Body Weight _____ pounds. Present Height _____ feet _____ inches
 Is there a family history of any type of disease (i.e. heart disease, cancer)?: _____

Please indicate if you have, or have had, any of the following disorders:

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel/Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Patient Signature _____ Date: _____