

Patient Basic Information

Personal Information:

Last Name:		First Name:	Mid. Init.:
Address:		City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:	
Date of Birth:		Date of Injury/Onset:	
Dominant Hand:		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
Insurance Information: Policy Holder (if different than patient):		Policy No.:	

~~Occupation~~

~~Cell Phone~~

~~Email~~

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

- Car Station Wagon
 Van Pickup Truck
 Large Truck Bus
 Other _____

2. Your position in vehicle

- Driver Front Passenger
 Left Rear Passenger
 Right Rear Passenger
 Other _____

3. What was your vehicle doing at the time of the accident?

- Stopped at intersection Stopped in traffic Stopped at light
 Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating
 Other _____

4. Time/Speed/Damage

Time of accident _____
 Your vehicle's speed: _____ mph
 Their vehicle's speed: _____ mph

Damage to your vehicle

- Mild Moderate
 Totaled

5. Details of Accident

Visibility at time of accident
 Poor Fair Good

Who hit who/what?

- You hit other vehicle
 Other vehicle hit you

You hit...(object)

6. Road conditions

Road conditions at time of accident
 Icy Wet Sandy Dark Clean and dry

Point of impact

- Head-On Left Front Right Front
 Rear-End Left Rear Right Rear

7. Body Position, etc.

- Did you see the accident coming? Yes No
 Were you braced for the impact? Yes No
 Did you have a seat belt on? Yes No
 Did you have a shoulder harness on? Yes No

Does your vehicle have headrests? Yes No

What was the position of your headrest at the time of the impact?

- Even with top of head Even with bottom of head Middle of neck

What was the direction of your head at the time of the impact?

- Facing straight forward Turned to the right Turned to the left

Did driver side air bags deploy? Yes No Did passenger side airbags deploy? Yes No Did side airbags deploy? Yes No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

- Did your body strike the inside of your vehicle? Yes No
 If yes, describe: _____
 Did you lose consciousness during the injury? Yes No
 If yes, for how long? _____
 Your vehicle's estimated damage? _____
Damage to their vehicle: Mild Moderate Totaled
 Did police show up at the scene? Yes No
 Was an accident report filled out? Yes No

10. After the accident:

Check off your symptoms right after and a few days following:

- Headache Dizziness Mid back pain Cold hands
 Neck pain Nausea Low back pain Cold feet
 Neck stiffness Confusion Nervousness Diarrhea
 Fainting Fatigue Loss of taste Depression
 Ringing in ears Tension Toe numbness Anxious
 Loss of smell Irritability Constipation Chest Pain
 Pain behind eyes Shortness of breath Sleeping problems
 Others: _____

11. Emergency Room?

- Where did you go after the accident?**
 Home Work Hospital ER Private Doctor
How did you get there?
 Drove self Somebody else Ambulance Police
Were X-rays done? Yes No **Was lab work done?** Yes No
 Body parts X-rayed? _____
 What lab work? _____
 The X-rays revealed: _____
Treatments: Cervical Collar Ice **Other:** _____
 Medications: _____
 Follow-up instructions: _____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.

- 1. Dr. _____** First visit date: ____/____/____
 Specialty: _____ X-rays done? Yes No
 Types of treatments received: _____
 How many treatments received? _____ Currently treating? Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
 Types of treatments received: _____
 How many treatments received? _____ Currently treating: Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)																																																																			
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Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

IV. Fourth Symptom: (Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)																																																																			
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4. Pain Intensity (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities	5. Does this pain radiate into other body parts? <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Both</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Head</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Leg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> Other locations of radiation: _____		Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																														
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Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty" **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing Drying hair Brushing teeth Putting on shoes Preparing meals Taking out trash
 Showering Combing hair Making bed Tying shoes Eating Doing laundry
 Washing hair Washing face Putting on shirt Putting on pants Cleaning dishes Going to toilet

Difficulties with Physical Activities

Standing Walking Kneeling Bending back Twisting left Leaning back
 Sitting Stooping Reaching Bending left Twisting right Leaning left
 Reclining Squatting Bending forward Bending right Leaning forward Leaning right
 Standing for long periods Sitting for long periods Walking for long periods Kneeling for long periods

Difficulties with Functional Activities

Carrying small objects Lifting weights off floor Pushing things while seated Exercising upper body
 Carrying large objects Lifting weights off table Pushing things while standing Exercising lower body
 Carrying brief case Climbing stairs Pulling things while seated Exercising arms
 Carrying large purse Climbing inclines Pulling things while standing Exercising legs

Difficulties with Social and Recreational Activities

Bowling Jogging Swimming Ice Skating Competitive Sports Dating
 Golfing Dancing Skiing Roller Skating Hobbies Dining out

Difficulties with Travelling

Driving a motor vehicle Riding as a passenger in a motor vehicle Riding as a passenger on a train
 Driving for long periods of time Riding as a passenger on an airplane Riding as a passenger for long periods

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating..... Hearing..... Listening..... Speaking..... Reading..... Writing..... Using a keyboard.....

Difficulties with the Senses

Seeing..... Hearing..... Sense of touch..... Sense of taste..... Sense of smell.....

Difficulties with Hand Functions

Grasping..... Holding..... Pinching..... Percussive movements..... Sensory discrimination.....

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep..... Being able to participate in desired sexual activity.....

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
- My current complaints DID exist before, but have not been bothering me.
- My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
- My history HAS NOT contributed to my current symptoms.
- I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred..... months ago / years ago Or on Date: ____/____/____

Write in below any other Prior Symptom History, not covered above:

Medical History

1. Are you now or have you suffered from the following? (Please write Past, Present, or Never in the blanks)

Arteriosclerosis _____	Double or Blurred Vision _____	Multiple Sclerosis _____
Asthma _____	Epilepsy _____	Polio _____
Arthritis _____	Heart Attack/Disease _____	Stroke _____
Cancer _____	High Blood Pressure _____	Ear Infections _____
Diabetes _____	Migraines _____	Rheumatic Fever _____
Dizziness/Fainting _____	Motion Sickness _____	Allergies _____
Anemia _____	Back Surgery _____	Influenza _____
HIV Infection _____	Pleurisy _____	Fatigue (Chronic) _____
Tuberculosis _____	Digestive Disorders _____	Sinus Trouble _____
Measles _____	Mumps _____	Pneumonia _____
Appendicitis _____	Thyroid Problems _____	TMJ _____
Carpal Tunnel _____	Venereal Disease _____	Low Blood Pressure _____
Scarlet Fever _____	Hepatitis _____	Ulcer _____
Kidney Disease _____	Depression _____	Drug or Alcohol Dependence _____
Eczema _____	Broken Bones _____	Gout _____
Chicken Pox _____		

Women Only:

- a. Are you pregnant or think you may be pregnant? _____
- b. Date of last menstrual period _____
- c. Do you or have you suffered from any menstrual disorders? _____
If yes, please describe _____

2. Do you have any condition, disease or problem not listed above? _____
If yes, please describe _____

3. Do you smoke or use any tobacco products? _____ If yes, how often? _____

4. Do you drink alcoholic beverages? _____ If yes, how often? _____

5. Do you drink caffeinated beverages? _____ If yes, how often? _____

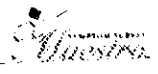
6. Have you had any other serious illness/trauma (falls, accidents), surgeries or been hospitalized? _____
If yes, describe _____

7. Please list **all** medications including birth control pills, aspirin, cortisone or vitamins that you are presently taking.

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health!

Date Patient's Signature

Reviewed By Doctor _____	Date _____	BP _____
History Review and Significant Findings: _____		



SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____
 Birth Date ____/____/____ Approx Weight _____ Sex: Male Female
 Pulse: Recumbent _____ Standing _____ Vegetarian: Yes No
 Blood pressure: Recumbent ____/____ Standing ____/____ Ragland's Test is Positive

INSTRUCTIONS: Fill in only the circles which apply to you.
 ● ○ ○ MILD symptoms (occur once or twice a year).
 ○ ● ○ MODERATE symptoms (occur several times a month).
 ○ ○ ● SEVERE symptoms (you are aware of it almost constantly).
 ○ ○ ○ Leave circles BLANK if they don't apply to you!

- | | |
|---|---|
| <p>1 2 3
 53 ○ ○ ○ Crave candy or coffee in afternoons
 54 ○ ○ ○ Moods of depression - "blues" or melancholy
 55 ○ ○ ○ Abnormal craving for sweets or snacks</p> <p>GROUP 4</p> <p>56 ○ ○ ○ Hands and feet go to sleep easily, numbness
 57 ○ ○ ○ Sigh frequently, "air hunger"
 58 ○ ○ ○ Aware of "breathing heavily"
 59 ○ ○ ○ High altitude discomfort
 60 ○ ○ ○ Opens windows in closed rooms
 61 ○ ○ ○ Susceptible to colds and fevers
 62 ○ ○ ○ Afternoon "yawner"
 63 ○ ○ ○ Get "drowsy" often
 64 ○ ○ ○ Swollen ankles, worse at night
 65 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
 66 ○ ○ ○ Shortness of breath on exertion
 67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion</p> <p>68 ○ ○ ○ Bruise easily, "black and blue" spots
 69 ○ ○ ○ Tendency to anemia
 70 ○ ○ ○ "Nose bleeds" frequent
 71 ○ ○ ○ Noises in head, or "ringing in ears"
 72 ○ ○ ○ Tension under the breastbone, or feeling of "tightness", worse on exertion</p> <p>GROUP 5</p> <p>73 ○ ○ ○ Dizziness
 74 ○ ○ ○ Dry skin
 75 ○ ○ ○ Burning feet
 76 ○ ○ ○ Blurred vision
 77 ○ ○ ○ Itching skin and feet
 78 ○ ○ ○ Excessive falling hair
 79 ○ ○ ○ Frequent skin rashes
 80 ○ ○ ○ Bitter, metallic taste in mouth in mornings
 81 ○ ○ ○ Bowel movements painful or difficult
 82 ○ ○ ○ Worrier, feels insecure
 83 ○ ○ ○ Feeling queasy, headache over eyes
 84 ○ ○ ○ Greasy foods upset
 85 ○ ○ ○ Stools light colored
 86 ○ ○ ○ Skin peels on foot soles
 87 ○ ○ ○ Pain between shoulder blades
 88 ○ ○ ○ Use laxatives
 89 ○ ○ ○ Stools alternate from soft to watery
 90 ○ ○ ○ History of gallbladder attacks or gallstones
 91 ○ ○ ○ Sneezing attacks
 92 ○ ○ ○ Dreaming, nightmare type bad dreams
 93 ○ ○ ○ Bad breath (halitosis)
 94 ○ ○ ○ Milk products cause distress
 95 ○ ○ ○ Sensitive to hot weather
 96 ○ ○ ○ Burning or itching anus
 97 ○ ○ ○ Crave sweets</p> <p>GROUP 6</p> <p>98 ○ ○ ○ Loss of taste for meat
 99 ○ ○ ○ Lower bowel gas several hours after eating
 100 ○ ○ ○ Burning stomach sensations, eating relieves
 101 ○ ○ ○ Coated tongue
 102 ○ ○ ○ Pass large amounts of foul-smelling gas
 103 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs
 104 ○ ○ ○ Mucous colitis or "irritable bowel"
 105 ○ ○ ○ Gas shortly after eating
 106 ○ ○ ○ Stomach "bloating" after eating</p> | <p>over please
 to continue</p> |
|---|---|

- 1 2 3 GROUP 1**
- 1 ○ ○ ○ Acid foods upset
 2 ○ ○ ○ Get chilled often
 3 ○ ○ ○ "Lump" in throat
 4 ○ ○ ○ Dry mouth-eyes-nose
 5 ○ ○ ○ Pulse speeds after meal
 6 ○ ○ ○ Keyed up - fail to calm
 7 ○ ○ ○ Cut heals slowly
 8 ○ ○ ○ Gag easily
 9 ○ ○ ○ Unable to relax; startles easily
 10 ○ ○ ○ Extremities cold, clammy
 11 ○ ○ ○ Strong light irritates
 12 ○ ○ ○ Urine amount reduced
 13 ○ ○ ○ Heart pounds after retiring
 14 ○ ○ ○ "Nervous" stomach
 15 ○ ○ ○ Appetite reduced
 16 ○ ○ ○ Cold sweats often
 17 ○ ○ ○ Fever easily raised
 18 ○ ○ ○ Neuralgia-like pains
 19 ○ ○ ○ Staring, blinks little
 20 ○ ○ ○ Sour stomach often
- GROUP 2**
- 21 ○ ○ ○ Joint stiffness on arising
 22 ○ ○ ○ Muscle-leg-toe cramps at night
 23 ○ ○ ○ "Butterfly" stomach, cramps
 24 ○ ○ ○ Eyes or nose watery
 25 ○ ○ ○ Eyes blink often
 26 ○ ○ ○ Eyelids swollen, puffy
 27 ○ ○ ○ Indigestion soon after meals
 28 ○ ○ ○ Always seems hungry; feels "lightheaded" often
 29 ○ ○ ○ Digestion rapid
 30 ○ ○ ○ Vomiting frequent
 31 ○ ○ ○ Hoarseness frequent
 32 ○ ○ ○ Breathing irregular
 33 ○ ○ ○ Pulse slow; feels "irregular"
 34 ○ ○ ○ Gagging reflex slow
 35 ○ ○ ○ Difficulty swallowing
 36 ○ ○ ○ Constipation, diarrhea alternating
 37 ○ ○ ○ "Slow starter"
 38 ○ ○ ○ Get "chilled" infrequently
 39 ○ ○ ○ Perspire easily
 40 ○ ○ ○ Circulation poor, sensitive to cold
 41 ○ ○ ○ Subject to colds, asthma, bronchitis
- GROUP 3**
- 42 ○ ○ ○ Eat when nervous
 43 ○ ○ ○ Excessive appetite
 44 ○ ○ ○ Hungry between meals
 45 ○ ○ ○ Irritable before meals
 46 ○ ○ ○ Get "shaky" if hungry
 47 ○ ○ ○ Fatigue, eating relieves
 48 ○ ○ ○ "Lightheaded" if meals delayed
 49 ○ ○ ○ Heart palpitates if meals missed or delayed
 50 ○ ○ ○ Afternoon headaches
 51 ○ ○ ○ Overeating sweets upsets
 52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep

0.1

1 2 3 GROUP 7A

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Thin, moist skin
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse fast at rest
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

GROUP 7B

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Mental sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising, wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7C

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

GROUP 7D

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

GROUP 7E

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

GROUP 7F

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma

1 2 3

- 170 Weakness after colds, influenza
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

GROUP 8

- 173 Apprehension
- 174 Irritability
- 175 Morbid fears
- 176 Never seems to get well
- 177 Forgetfulness
- 178 Indigestion
- 179 Poor appetite
- 180 Craving for sweets
- 181 Muscular soreness
- 182 Depression; feelings of dread
- 183 Noise sensitivity
- 184 Acoustic hallucinations
- 185 Tendency to cry without reason
- 186 Hair is coarse and/or thinning
- 187 Weakness
- 188 Fatigue
- 189 Skin sensitive to touch
- 190 Tendency toward hives
- 191 Nervousness
- 192 Headache
- 193 Insomnia
- 194 Anxiety
- 195 Anorexia
- 196 Inability to concentrate; confusion
- 197 Frequent stuffy nose; sinus infections
- 198 Allergy to some foods
- 199 Loose joints

FEMALE ONLY

- 200 Very easily fatigued
- 201 Premenstrual tension
- 202 Painful menses
- 203 Depressed feelings before menstruation
- 204 Menstruation excessive and prolonged
- 205 Painful breasts
- 206 Menstruate too frequently
- 207 Vaginal discharge
- 208 Hysterectomy/ovaries removed
- 209 Menopausal hot flashes
- 210 Menses scanty or missed
- 211 Acne, worse at menses
- 212 Depression of long standing

MALE ONLY

- 213 Prostate trouble
- 214 Urination difficult or dribbling
- 215 Night urination frequent
- 216 Depression
- 217 Pain on inside of legs or heels
- 218 Feeling of incomplete bowel evacuation
- 219 Lack of energy
- 220 Migrating aches and pains
- 221 Tire too easily
- 222 Avoids activity
- 223 Leg nervousness at night
- 224 Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

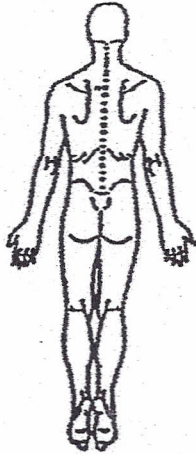
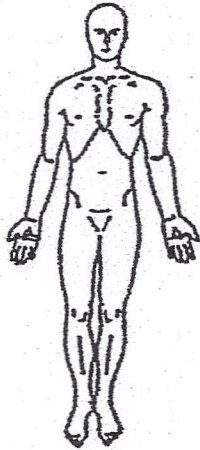
HISTORY OF INJURIES

NAME _____

DATE _____

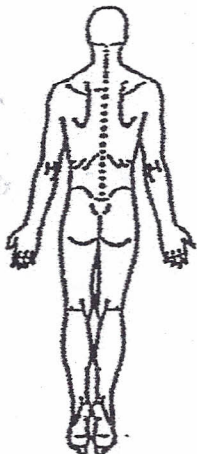
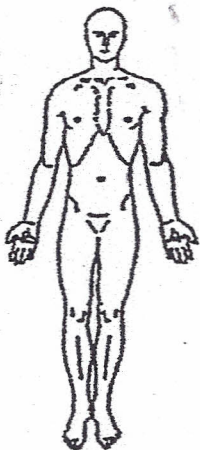
PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED

Sprains/Strains, Broken Bones, Severe Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, etc.



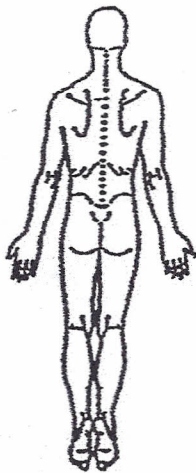
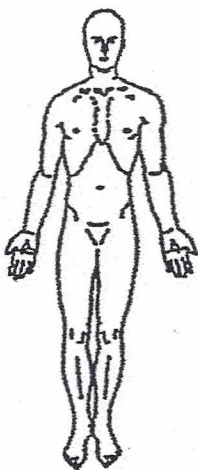
What happened?

When did it happen?



What happened?

When did it happen?



What happened?

When did it happen?