

MEDICAL HISTORY

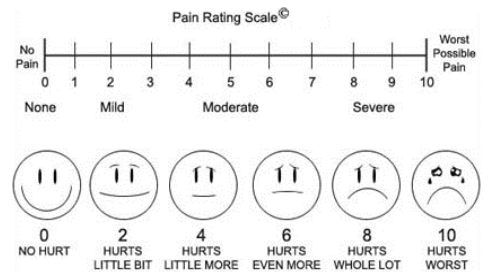
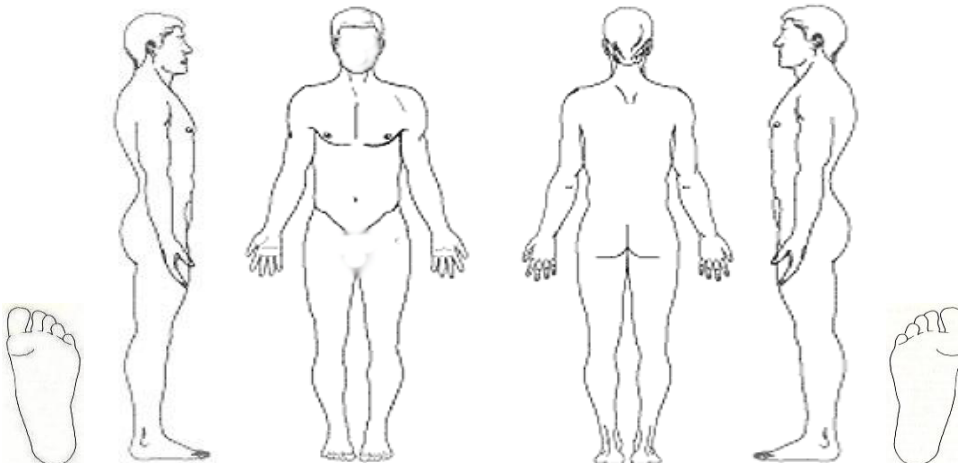
Please Check () for symptoms you currently have or have had in the past year

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Ear Ache | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Impotence | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Arm/Shoulder Pains | <input type="checkbox"/> Fatigue Syndrome | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Joint Pain/Swelling | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Genital Pain | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shingle |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Nerve Related Problem | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Thyroid <input type="checkbox"/> Over-active |
| <input type="checkbox"/> Coccyx | <input type="checkbox"/> Non-A, Non-B | <input type="checkbox"/> Neuroma | <input type="checkbox"/> Under-active |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Herpes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Uric Acid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Pelvic | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV or AIDS | | |

PAIN DIAGRAM

Mark on the diagram below where your pain is located.

Right Side Front Back Left Side



- 1) Burning pain
- 2) Tenderness pain
- 3) Stabbing pain
- 5) Pain
- 4) Aching – Throbbing pain
- 6) Shooting pain
- 7) Electric Shock-like pain
- 8) Tingling Pain & needles pain
- 9) Numbness

I have Chronic Pains:

- | | | | | | |
|---------------------------------|----------------------------------|-----------------------------------|--|-------------------------------------|-------------------------------|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot | <input type="checkbox"/> Jaw | <input type="checkbox"/> Legs | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Gastric | <input type="checkbox"/> Hip | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> X-Ray | <input type="checkbox"/> None |
| <input type="checkbox"/> Coccyx | <input type="checkbox"/> Stomach | <input type="checkbox"/> Headache | <input type="checkbox"/> Lumbar Region | <input type="checkbox"/> MRI | |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee | <input type="checkbox"/> Hand | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Ultrasound | |
| <input type="checkbox"/> Finger | <input type="checkbox"/> Joints | <input type="checkbox"/> Groin | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> CT Scan | |

Patient's Signature: _____

Date: _____