

## New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data						
First Name	Last Name					
Date Email*						
* Your email will NOT be shared with any 3d parties, and is used for	r occasional office announcements and promotions.					
Mailing Address						
Address						
	State Zip					
Phone Work ( )	_ Home ()					
Referred By						
	/ # Number of Children					
	Employer					
Spouse's Occupation	Spouse's Employer					
Spouse's Health Status						
Emergency Contact	Phone ()					
Nature of Injury:						
Please Describe:						
Date of Injury / / Date Symptoms Appe	eared / /					
Have you ever had same condition?   Yes   No If Yes, When?						
List of other practitioners seen for this injury/condition						
Have you ever been under chiropractic care?						
If Yes, Please Describe						
Insurance Information						
Name of Party Responsible for Payment						
Phone ( ) Do you h	nave health insurance? 🗆 Yes 🗆 No					
Name of Company						
* If an auto accident, please provide:						
Insurance Company Name:						
Contact Person	Phone ()					

## Signatures

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. I authorize the Chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Chiropractor or Chiropractic group insurance benefits otherwise payable to me. I understand that my Chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

## Name of the Insured

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. I authorize the Chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Chiropractor or Chiropractic group insurance benefits otherwise payable to me. I understand that my Chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	_ Date	/	/
Spouse's or Guardian's Signature			
Medical History			
Have you been treated for any conditions in the last year? ☐ Yes ☐ No  If Yes, Please Describe			
Date of Last Physical Exam/ Is there a chance that you are pregnant? Have you had X-rays taken?   Yes  No If Yes, Where?			
What medications are you taking and for what conditions (Please list dosage and amo			
What vitamins, minerals, or herbs do you currently take? (Please list for what condition frequency.)	ns, dosag	ge, and	d
Have you ever:			
Broken bones? ☐ Yes ☐ No Please Briefly Explain			
Been hospitalized? ☐ Yes ☐ No Please Briefly Explain			
Been in an auto accident? ☐ Yes ☐ No Please Briefly Explain			
Had Sprains/Strains? ☐ Yes ☐ No Please Briefly Explain			
Been struck unconscious?   Yes   No Please Briefly Explain			
Had surgery? ☐ Yes ☐ No Please Briefly Explain			
Family History			

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.):

Do you experience pain every day?   Yes   No Do your symptoms interfere with daily life?   Yes   No Does pain wake you up at night?   Yes   No Does pain wake you up at night?   Yes   No Do changes in weather affect your symptoms?   Yes   No Do you wear orthotics?   Yes   No Do you ware orthotics?   Yes   No Do you take vitamin supplements?   Yes   No What activities aggravate your symptoms?    ### With a company of the com						
Do your symptoms interfere with daily life?   Yes   No Does pain wake you up at night?   Yes   No Are your symptoms worse during certain times of the day?   Yes   No Do you wear orthotics?   Yes   No Do you wate vitamin supplements?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol						
Do your symptoms interfere with daily life?   Yes   No Does pain wake you up at night?   Yes   No Are your symptoms worse during certain times of the day?   Yes   No Do changes in weather affect your symptoms?   Yes   No Do you ware orthotics?   Yes   No Do you take vitamin supplements?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol   None   Light   Moderate   Heavy Coffee   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Appetite   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Salty Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Artificial Sweetners   None   Light   Moderate   Heavy  Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy Arthritis   Frequent Urination   Nosebleeds   Pootsure   Pootsure   Arthritis   Frequent Urination   Poor Posture   Pootsure   Arthritis   Hot Flashes   Sinus Infection   Brack Pain   Hemorrhoids   Sciatica   Shortness of Irosath   Breast Lump   High Blood Pressure   Shortness of Irosath   Bronchitis   Hot Flashes   Sinus Infection   Stroke   Cancer   Irregular Acycle   Spinal Curvatures   Chest Pain/Conditions   Kidney Infection   Stroke   Swelling of ankles   Constipation   Loss of memory   Swelling of ankles   Constipation   Constitute   Constitute   Constitute   Constitute   Constitute   Constitute   Consti						
Do your symptoms interfere with daily life?   Yes   No Does pain wake you up at night?   Yes   No Are your symptoms worse during certain times of the day?   Yes   No Do changes in weather affect your symptoms?   Yes   No Do you ware orthotics?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol   None   Light   Moderate   Heavy Coffee   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Appetite   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Salty Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Artificial Sweetners   None   Light   Moderate   Heavy Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy Arthritis   Prequent Urination   Nosebleeds   Polio   Arthritis   Prequent Urination   Poor Posture   Arthritis   Prequent Urination   Poor Posture   Back Pain   Headche   Prostate Trouble   Brask Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of Insomnia   Breast Lump   High Blood Pressure   Shortness of Insomni						
Do your symptoms interfere with daily life?   Yes   No Does pain wake you up at night?   Yes   No Are your symptoms worse during certain times of the day?   Yes   No Do changes in weather affect your symptoms?   Yes   No Do you ware orthotics?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol   None   Light   Moderate   Heavy Coffee   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Appetite   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Salty Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Artificial Sweetners   None   Light   Moderate   Heavy Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy Arthritis   Prequent Urination   Nosebleeds   Polio   Arthritis   Prequent Urination   Poor Posture   Arthritis   Prequent Urination   Poor Posture   Back Pain   Headche   Prostate Trouble   Brask Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of Insomnia   Breast Lump   High Blood Pressure   Shortness of Insomni						
Do your symptoms interfere with daily life?   Yes   No Does pain wake you up at night?   Yes   No Are your symptoms worse during certain times of the day?   Yes   No Do changes in weather affect your symptoms?   Yes   No Do you ware orthotics?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol   None   Light   Moderate   Heavy Coffee   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Drugs   None   Light   Moderate   Heavy Sercise   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Appetite   None   Light   Moderate   Heavy Soft Drinks   None   Light   Moderate   Heavy Salty Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Sugary Foods   None   Light   Moderate   Heavy Artificial Sweetners   None   Light   Moderate   Heavy Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy Arthritis   Prequent Urination   Nosebleeds   Polio   Arthritis   Prequent Urination   Poor Posture   Arthritis   Prequent Urination   Poor Posture   Back Pain   Headche   Prostate Trouble   Brask Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of Insomnia   Breast Lump   High Blood Pressure   Shortness of Insomni	Do you experience pain or	vory day? 🗆 Vos [	¬ No			
Does pain wake you up at night?   Yes   No Are your symptoms worse during certain times of the day?   Yes   No Do changes in weather affect your symptoms?   Yes   No Do you wear orthotics?   Yes   No Do you take vitamin supplements?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol						
Are your symptoms worse during certain times of the day?   Yes   No   Do changes in weather affect your symptoms?   Yes   No   Do you wear orthotics?   Yes   No   What activities aggravate your symptoms?		-				
Do changes in weather affect your symptoms?   Yes   No   Do you war orthotics?   Yes   No   What activities aggravate your symptoms?    Habits  Alcohol				s 🗆 No		
Do you wear orthotics?   Yes   No Do you take vitamin supplements?   Yes   No What activities aggravate your symptoms?    Habits  Alcohol		_	-	3 🗆 110		
Do you take vitamin supplements?	~					
What activities aggravate your symptoms?           Habits           Alcohol         None         Light         Moderate         Heavy           Coffee         None         Light         Moderate         Heavy           Tobacco         None         Light         Moderate         Heavy           Drugs         None         Light         Moderate         Heavy           Exercise         None         Light         Moderate         Heavy           Sleep         None         Light         Moderate         Heavy           Appetite         None         Light         Moderate         Heavy           Soft Drinks         None         Light         Moderate         Heavy           Water         None         Light         Moderate         Heavy           Salty Foods         None         Light         Moderate         Heavy           Sugary Foods         None         Light         Moderate         Heavy           Artificial Sweeteners         None         Light         Moderate         Heavy           Have you ever suffered from:         Sciatica         Heavy           Alcoholism         Bras Ring         Nervousness         Nervousness <th>•</th> <th></th> <th>∃No</th> <th></th> <th></th>	•		∃No			
Habits  Alcohol						
Alcohol   None   Light   Moderate   Heavy   Coffee   None   Light   Moderate   Heavy   Tobacco   None   Light   Moderate   Heavy   Drugs   None   Light   Moderate   Heavy   Exercise   None   Light   Moderate   Heavy   Sleep   None   Light   Moderate   Heavy   Sleep   None   Light   Moderate   Heavy   Sleep   None   Light   Moderate   Heavy   Appetite   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Salty Foods   None   Light   Moderate   Heavy   Salty Foods   None   Light   Moderate   Heavy   Sugary Foods   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy    Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy   Allergies   Excessive Menstruation   Nosebleeds   Anemia   Eye Pain or Difficulties   Pacemaker   Arthritis   Frequent Urination   Poor Posture   Asthma   Headache   Prostate Trouble   Back Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of breath   Bronchitis   Herorrhoids   Sinus Infection   Bronse Easily   Irregular Peart Beat   Sleep problems or Insomnia   Bruise Easily   Irregular Peart Beat   Sleep problems or Insomnia   Bruise Easily   Irregular Cycle   Spinal Curvatures   Condition   Loss of memory   Swelling of ankles   Constipation   Loss of femory   Swelling of ankles   Constipation   Loss of balance   Thyroid Condition		y c a.				
Alcohol   None   Light   Moderate   Heavy   Coffee   None   Light   Moderate   Heavy   Tobacco   None   Light   Moderate   Heavy   Tobacco   None   Light   Moderate   Heavy   Drugs   None   Light   Moderate   Heavy   Stevercise   None   Light   Moderate   Heavy   Step   None   Light   Moderate   Heavy   Step   None   Light   Moderate   Heavy   Appetite   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Salty Foods   None   Light   Moderate   Heavy   Salty Foods   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy    Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy   Allergies   Excessive Menstruation   Nosebleeds   Anemia   Eye Pain or Difficulties   Pacemaker   Arthritis   Frequent Urination   Poor Posture   Asthma   Headache   Prostate Trouble   Back Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of breath   Bronchitis   Hot Flashes   Sinus Infection   Bronse Easily   Irregular Pleart Beat   Sleep problems or Insomnia   Bruise Easily   Irregular Pleart Beat   Sleep problems or Insomnia   Cancer   Irregular Cycle   Spinal Curvatures   Cold Extremities   Kidney Infection   Stroke   Cold Extremities   Swelling of ankles   Constipation   Loss of memory   Swelling of ankles   Constipation   Loss of balance   Thyroid Condition						
Coffee	Habits					
Coffee	Alcohol	☐ None	□ Light	☐ Moderate	☐ Heavy	
Tobacco	Coffee	□ None	~	☐ Moderate	•	
Drugs   None   Light   Moderate   Heavy   Exercise   None   Light   Moderate   Heavy   Sleep   None   Light   Moderate   Heavy   Appetite   None   Light   Moderate   Heavy   Appetite   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Water   None   Light   Moderate   Heavy   Water   None   Light   Moderate   Heavy   Salty Foods   None   Light   Moderate   Heavy   Sugary Foods   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy   Wave you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Heavy   Allergies   Excessive Menstruation   Nosebleeds   Anemia   Eye Pain or Difficulties   Pacemaker   Arteriosclerosis   Fatigue   Polio   Arthritis   Frequent Urination   Poor Posture   Asthma   Headache   Prostate Trouble   Back Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of breath   Bronchitis   Hot Flashes   Sinus Infection   Bruise Easily   Irregular Heart Beat   Sleep problems or Insomnia   Cancer   Irregular Cycle   Spinal Curvatures   Chest Pain/Conditions   Kidney Infection   Stroke   Chest Pain/Conditions   Kidney Stones   Swelling of ankles   Constipation   Loss of memory   Swollen Joints   Cramps   Loss of balance   Thyroid Condition	Tobacco	☐ None	~	☐ Moderate		
Sleep   None   Light   Moderate   Heavy   Appetite   None   Light   Moderate   Heavy   Soft Drinks   None   Light   Moderate   Heavy   Water   None   Light   Moderate   Heavy   Salty Foods   None   Light   Moderate   Heavy   Sugary Foods   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy    Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness   Allergies   Excessive Menstruation   Nosebleeds   Anemia   Eye Pain or Difficulties   Pacemaker   Arteriosclerosis   Fatigue   Polio   Arthritis   Frequent Urination   Poor Posture   Asthma   Headache   Prostate Trouble   Back Pain   Hemorrhoids   Sciatica   Breast Lump   High Blood Pressure   Shortness of breath   Bronchitis   Hot Flashes   Sinus Infection   Bruise Easily   Irregular Heart Beat   Sleep problems or Insomnia   Cancer   Irregular Cycle   Spinal Curvatures   Chest Pain/Conditions   Kidney Infection   Stroke   Chest Pain/Conditions   Kidney Infection   Stroke   Cold Extremities   Kidney Stones   Swelling of ankles   Constipation   Loss of memory   Swollen Joints   Cramps   Loss of balance   Thyroid Condition	Drugs	☐ None		☐ Moderate		
Appetite	Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy	
Soft Drinks   None	Sleep	☐ None	□ Light	☐ Moderate	☐ Heavy	
Water	Appetite	☐ None	☐ Light	☐ Moderate	□ Heavy	
Salty Foods   None   Light   Moderate   Heavy   Sugary Foods   None   Light   Moderate   Heavy   Artificial Sweeteners   None   Light   Moderate   Heavy    Have you ever suffered from:    Alcoholism   Ears Ring   Nervousness     Allergies   Excessive Menstruation   Nosebleeds     Anemia   Eye Pain or Difficulties   Pacemaker     Arteriosclerosis   Fatigue   Polio     Arthritis   Frequent Urination   Poor Posture     Asthma   Headache   Prostate Trouble     Back Pain   Heigh Blood Pressure   Shortness of breath     Bronchitis   Hot Flashes   Sinus Infection     Bruise Easily   Irregular Heart Beat   Sleep problems or Insomnia     Cancer   Irregular Cycle   Spinal Curvatures     Chest Pain/Conditions   Kidney Infection   Stroke     Cold Extremities   Kidney Stones   Swelling of ankles     Constipation   Loss of memory   Swollen Joints     Cramps   Loss of balance   Thyroid Condition	Soft Drinks	☐ None	☐ Light	☐ Moderate	☐ Heavy	
Sugary Foods	Water	☐ None	☐ Light	☐ Moderate	☐ Heavy	
Artificial Sweeteners       None       Light       Moderate       Heavy         Have you ever suffered from:         Alcoholism       Ears Ring       Nervousness         Allergies       Excessive Menstruation       Nosebleeds         Anemia       Eye Pain or Difficulties       Pacemaker         Arteriosclerosis       Fatigue       Polio         Arthritis       Frequent Urination       Poor Posture         Asthma       Headache       Prostate Trouble         Back Pain       Hemorrhoids       Sciatica         Breast Lump       High Blood Pressure       Shortness of breath         Bronchitis       Hot Flashes       Sinus Infection         Bruise Easily       Irregular Heart Beat       Sleep problems or Insomnia         Cancer       Irregular Cycle       Spinal Curvatures         Chest Pain/Conditions       Kidney Infection       Stroke         Cold Extremities       Kidney Stones       Swelling of ankles         Constipation       Loss of memory       Swollen Joints         Cramps       Loss of balance       Thyroid Condition	Salty Foods	☐ None	☐ Light	☐ Moderate	☐ Heavy	
Have you ever suffered from:  Alcoholism	Sugary Foods	☐ None	☐ Light	☐ Moderate	☐ Heavy	
□ Alcoholism       □ Ears Ring       □ Nervousness         □ Allergies       □ Excessive Menstruation       □ Nosebleeds         □ Anemia       □ Eye Pain or Difficulties       □ Pacemaker         □ Arteriosclerosis       □ Fatigue       □ Polio         □ Arthritis       □ Frequent Urination       □ Poor Posture         □ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	Artificial Sweeteners	☐ None	☐ Light	☐ Moderate	☐ Heavy	
□ Alcoholism       □ Ears Ring       □ Nervousness         □ Allergies       □ Excessive Menstruation       □ Nosebleeds         □ Anemia       □ Eye Pain or Difficulties       □ Pacemaker         □ Arteriosclerosis       □ Fatigue       □ Polio         □ Arthritis       □ Frequent Urination       □ Poor Posture         □ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition						
□ Allergies       □ Excessive Menstruation       □ Nosebleeds         □ Anemia       □ Eye Pain or Difficulties       □ Pacemaker         □ Arteriosclerosis       □ Fatigue       □ Polio         □ Arthritis       □ Frequent Urination       □ Poor Posture         □ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	Have you ever suffere	ed from:				
□ Allergies       □ Excessive Menstruation       □ Nosebleeds         □ Anemia       □ Eye Pain or Difficulties       □ Pacemaker         □ Arteriosclerosis       □ Fatigue       □ Polio         □ Arthritis       □ Frequent Urination       □ Poor Posture         □ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	☐ Alcoholism	□ Ear	rs Ring	☐ Nervousness		
□ Arteriosclerosis       □ Fatigue       □ Polio         □ Arthritis       □ Frequent Urination       □ Poor Posture         □ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	□ Allergies					
□ Arthritis       □ Frequent Urination       □ Poor Posture         □ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	☐ Anemia	emia □ Eye		☐ Pacemak	□ Pacemaker	
□ Asthma       □ Headache       □ Prostate Trouble         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Thyroid Condition	☐ Arteriosclerosis	☐ Fatigue		☐ Polio		
□ Back Pain       □ Hemorrhoids       □ Sciatica         □ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	☐ Arthritis	□ Fre	$\square$ Frequent Urination		☐ Poor Posture	
□ Breast Lump       □ High Blood Pressure       □ Shortness of breath         □ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	☐ Asthma	□ Hea	☐ Headache		☐ Prostate Trouble	
□ Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	☐ Back Pain	□ He	☐ Hemorrhoids			
□ Bruise Easily       □ Irregular Heart Beat       □ Sleep problems or Insomnia         □ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Thyroid Condition	•		☐ High Blood Pressure			
□ Cancer       □ Irregular Cycle       □ Spinal Curvatures         □ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition						
□ Chest Pain/Conditions       □ Kidney Infection       □ Stroke         □ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition	☐ Bruise Easily	_				
□ Cold Extremities       □ Kidney Stones       □ Swelling of ankles         □ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition						
□ Constipation       □ Loss of memory       □ Swollen Joints         □ Cramps       □ Loss of balance       □ Thyroid Condition						
☐ Cramps ☐ Loss of balance ☐ Thyroid Condition						
•			-			
·		☐ Loss of smell				
□ Diabetes □ Loss of taste □ Ulcers □ Variance Voins					Voins	
<ul><li>□ Digestion Problems</li><li>□ Lumps In Breast</li><li>□ Varicose Veins</li><li>□ Dizziness</li><li>□ Neck Pain or Stiffness</li></ul>				□ varicose	VEILIS	

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

**A=**Ache **O=**Other **B=**Burning P=Pins & Needles **N=**Numbness

**S=**Stabbing