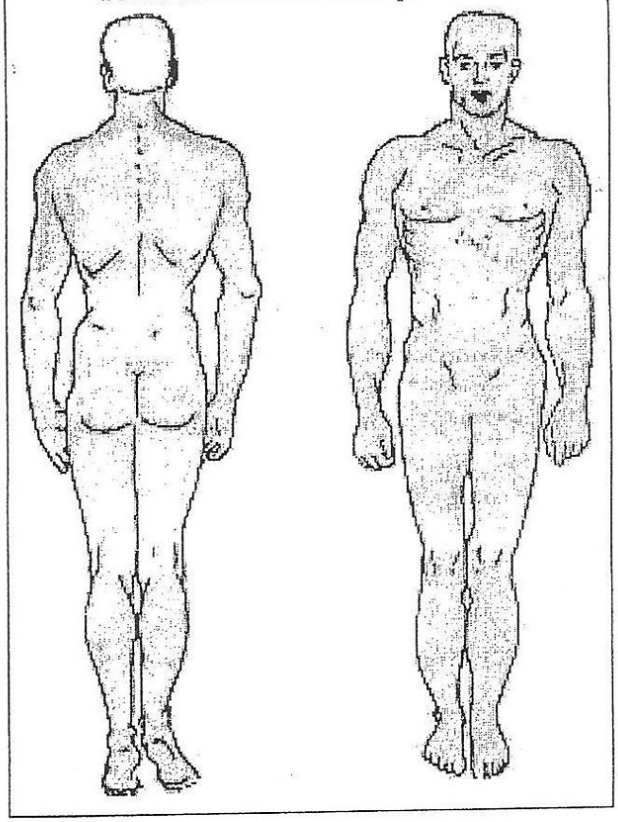
Please Fill in Below If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other joint pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Frequent colds	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest pains	☐	☐
Female problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Digestive problem	☐	☐
Urinary Problems	☐	☐
Skin conditions	☐	☐
Other _____	☐	☐

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____