# PATIENT INFORMATION SHEET

Date:____________________ Patient Name:_________________________________________

Address:________________________________________________________________________

Home Phone (     )______________ Cell (     )__________________ Work (     )____________

Email:_______________________________________ Sex: Male_______ Female_________

Birthdate: ______________ Single___ Married ___ Widowed ___ Separated __ Divorced ___

SS# ( last 4 digits) _______________________ Occupation: ____________________________

Spouse's Name: __________________________ Spouse's Birth date:______________________

Spouse's Occupation: _____________________________________________________________

Whom may we thank for referring you?______________________________________________

In case of an emergency who should we contact? _____________________________________

Relationship______________ Home phone__________ Work phone__________ Cell________

## INSURANCE INFORMATION

Name of your insurance company __________________________________________________

Policy # ___________________________________________ Group # _______________________

Claim address ____________________________________________________________________

Primary insured on the policy: ________________________ Relationship to you: ___________

Primary insured's date of birth: ____________________________________________________

Primary insured's address if different than yours: _______________________________________

# PATIENT CONDITION

Reason for visit:_______________________________________________________________

_____________________________________________________________________________

Date of first symptom: _________When did you first seek treatment for this

condition?___________ Has another doctor treated you for this condition: Yes__ No __

Whom? ☐MD ☐DO ☐DDS ☐DC ☐Other______ Name: ______________________________

Name of primary doctor_____________________________________________________

Have you tried: ☐Medication ☐Surgery ☐Lifestyle change ☐Chiropractic
☐Other_________________________________________________________________

Have you had any intolerance or reaction to treatments? ☐Yes ☐No

Describe:_______________________________________________________________

Is your condition due to an accident: Yes ____ No____

Date of accident: ____________________________________________________________

Has it become worse recently? ☐Yes ☐No ☐Same ☐Better ☐Gradually worse

Frequency of symptoms? ☐Constant ☐Daily ☐Intermittent

How long does it last? ☐All day ☐Few hours ☐Minutes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Recreation

Does anything relieve the symptom(s)? ☐Yes ☐No ☐Medication (prescription or OTC)
☐Rest ☐Exercise/stretch ☐Other:__________________________________________

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years

Describe the pain/symptoms: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning
☐Stabbing ☐Other:_________________________________________________________

What makes the symptoms worse? ☐Standing ☐Sitting ☐Lying ☐Lifting ☐Twisting
Other:_____________________________________________________________________

What do you believe is the cause of the symptoms?________________________________

What are your health goals?__________________________________________________

## NECK, BACK, EXTREMITIES

Please check the proper box to indicate if you have **ever** had the following:

***Neck***

- ☐Pain in neck
- ☐Neck stiffness
- ☐Neck weakness
- ☐Pinched nerve in neck
- ☐Neck feels out of place
- ☐Muscle spasms
- ☐Grinding/popping sounds

***Mid-back***

- ☐Mid-back pain
- ☐Mid-back stiffness
- ☐Pain between shoulders
- ☐Pain from front to back
- ☐Muscle spasms in back

***Low back***

- ☐Low back pain
- ☐Low back stiffness
- ☐Low back weakness
- ☐Pinched Nerve
- ☐Feels out of place
- ☐Muscle spasms

***Shoulders***

- ☐Pain in shoulder joint ☐Right ☐Left
- ☐Pain across shoulders
- ☐Can't raise arm ☐Right ☐Left
- ☐Can't raise arm above shoulder level
- ☐ Can't raise arm over head
- ☐Tension in shoulders
- ☐Shoulder pinched nerve ☐Right ☐Left

***Arms & Hands***

- ☐Pain in upper arms ☐Right ☐Left
- ☐Pain in elbow ☐Right ☐Left
- ☐Pain in forearm ☐Right ☐Left
- ☐Pain in hand ☐Right ☐Left
- ☐Pain in fingers ☐Right ☐Left
- ☐Pins & Needles arm ☐Right ☐Left
- ☐Pins & Needles fingers ☐Right ☐Left
- ☐Numbness in arm ☐Right ☐Left
- ☐Numbness in fingers ☐Right ☐Left
- ☐Weakness of arm ☐Right ☐Left

- ☐Weakness of hand ☐Right ☐Left
- ☐Hands are cold ☐Right ☐Left

***Hips, Legs, Feet***

- ☐Pain in buttocks ☐Right ☐Left
- ☐Pain in hip joint ☐Right ☐Left
- ☐Pain down leg ☐Right ☐Left
- ☐Pain in knee ☐Right ☐Left
- ☐Pain in ankle ☐Right ☐Left

**Circle the severity of the physical discomfort on the following scale: (1) is the least amount of discomfort and (10) is the most severe discomfort**

**0 1 2 3 4 5 6 7 8 9 10**

**Please use these symbols on the diagram to illustrate areas of physical discomfort:**

**XXX = pain** **OOO = numbness**

**SSS = tingling** **AAA = other**

☐Pain in Foot ☐Right ☐Left
☐Weakness of leg ☐Right ☐Left
☐Weakness of knee ☐Right ☐Left
☐Leg cramps ☐Right ☐Left

## FAMILY HEALTH HISTORY

Is your father living? ☐Yes ☐No If yes, how old is he? _______
Please list any medical problems:_______________________________________________________
If no, what was the cause of his death?_________________________________________________
Age at death:________

If your mother living? ☐Yes ☐No If yes, how old is she? _______
Please list any medical problems:_______________________________________________________
If no, what was the cause of his death? _________________________________________________
Age at death: _______

Check below if the following conditions occur within your family history (parents, grandparents, siblings, aunts and uncles):

***Relationship to you:***

☐ Heart disease (heart attacks under 55 years of age ________________________________

☐ High blood pressure ________________________________

☐ Diabetes ________________________________

☐ Stroke ________________________________

☐ Cancer ________________________________

## SURGERIES/SCARS

Please list and explain any injuries or surgeries you have had:
☐ Falls_________________ Date_______ ☐ Surgeries________________ Date______
☐ Head injuries_________ Date________ ☐ Broken bones_____________ Date______
☐ Dislocations__________ Date______ ☐ Other________________ Date______
Do you have any scars? ☐No ☐Yes Where?__________________________________________

## DENTAL HEALTH

Have you had any of the following dental work done?

- ☐ Root canals
- ☐ Implants
- ☐ Gingivitis
- ☐ Jacket crown
- ☐ Amalgams

## FOR WOMEN

Last menstrual period:_______ Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Date of last pap smear:___________ Have you had an abortion: ☐Yes ☐No

Have you had a mammogram: ☐Yes ☐No Number of children: _____________

## DIETARY INFORMATION

How many meals do you eat per day? ____ Do you snack? ☐Yes ☐No
What foods do you eat throughout the day?
______________________________________________________________________________________
______________________________________________________________________________________

## BEVERAGE INTAKE

How much water do you drink every day? ____ Is it filtered, bottled, from the tap?(circle one)
Do you drink sodas?____ If so, how many and what type? ______________________________
Do you drink coffee/tea? _________ Regular or decaf?
What do you put in your coffee/tea? (please circle) Cream, Sugar, Sweet &Low , Equal,
Coffee Mate, Other: ____________________________________________________________
Do you drink alcohol? ☐Yes ☐No What type? _________How many drinks per week?_____

## SLEEP HABITS

How many hours of sleep do you typically get? ______
What position do you sleep in at night (please circle): on my back, on my side, on my stomach
Do you have difficulty with sleeping? ☐Yes ☐No Please describe:
______________________________________________________________________________________
______________________________________________________________________________________

## PHYSICAL ACTIVITY

What is your level of exercise? Please circle one: none, a little, moderate, heavy
Please describe your exercise regimen: ______________________________________________
______________________________________________________________________________
What is your activity level at work? Please circle: sitting, standing, light labor, heavy labor

# GENERAL PATIENT CONSENTS AND ACKNOWLEDGEMENTS

Patient Policies

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

To maintain a peaceful atmosphere we ask that cell phones are silenced and all calls are taken outside.

Consent to Treat

I hereby consent to medical and chiropractic treatment as provided by PureBalance,
Thomas F. Bayne DC, and/or Ingrid Maes DC, as determined by Dr. Bayne or Dr. Maes's diagnosis and professional judgment. If I do not agree to a course of treatment, I will raise that concern and discuss it with Drs. Bayne or Maes prior to the administration of the treatment.

If you've had a change in symptoms, become (or potentially become) pregnant or been involved in an accident (work, auto or otherwise) since your last visit, it is your obligation to report this to your doctor prior to treatment.

Payment Policy

The patient is responsible for all charges at the time services are rendered. Payment is accepted in cash, check or credit card form. There is a $25 charge for non sufficient fund checks.

If your insurance company covers chiropractic care, we will be happy to provide you with a form detailing your visit that you can submit. If your insurance covers our services, you will be reimbursed directly. It is not our policy, under any circumstances, to submit bills to your
insurance company. By signing this, you authorize our office to furnish any necessary information requested by your insurance company to process the claims you have submitted.

Refund Policy

The company does not provide refund for treatments and professional chiropractic services. For products purchased, such as supplements, vitamins or other supplies, a patient may return such items, if unopened and unused and in re-sale condition within 30 days of the purchase. Refunds must be approved by office administration and will be provided in the same payment form in which the patient has made payment.

I understand and agree to the above.

Signed_______________________________________________ Dated_______________

# PATIENT SYMPTOM SURVEY

***DATE________________***

***PATIENT'S NAME________________________________ AGE___________***

***WEIGHT______ HEIGHT______ BLOOD PRESSURE________ PULSE______ $O_2$_______***

*This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 1-2 times per week is notable and would be marked. Please take your time…*

## Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder 692.9
002 ☐ Acne 706.1
003 ☐ Psoriasis 696.1
004 ☐ Urticaria (Hives) 708.9
005 ☐ ADD/ADHD 314.00/314.01
006 ☐ Allergies, Unspecified 477.9
007 ☐ Allergic Rhinitis from food 477.1
008 ☐ Sinusitis 461.9
009 ☐ Alzheimer's 331.0
010 ☐ Poor Concentration/ Memory 310.1
011 ☐ Parkinson's Disease 332.0
012 ☐ Anemia 285.9
013 ☐ Arthritic Disorder 716.90
014 ☐ Osteoporosis 733.00
015 ☐ Asthma 493.90
016 ☐ Emphysema 492.8
017 ☐ Cancer
- 018 ☐ Breast 174.9female 175.9male
- 019 ☐ Prostate 185
- 020 ☐ Lung 162.9
- 021 ☐ Colon and Rectal 153.9
- 022 ☐ Skin 173.9
- 023 ☐ Leukemia w/o remission 208.90
  Leukemia w/ remission 208.91
- 024 ☐ Lymphoma, malignant 202.8
- 025 ☐ Brain Tumor, malignant 191.9
- 026 ☐ Other

027 ☐ Anxiety Disorder 300.00
028 ☐ Autism 299.00
033 ☐ Edema 782.3
034 ☐ Eczema 692.9
035 ☐ Chronic Fatigue 780.71
036 ☐ Circulatory Disorder 459.9

037 ☐ Heart Disease 429.9
038 ☐ High Cholesterol 272.0
039 ☐ High Blood Pressure 401.9
040 ☐ Low Blood Pressure458.9
041 ☐ Tachycardia (High Heart Rate) 785.00
042 ☐ Numbness 782.0
043 ☐ Constipation 564.0
044 ☐ Indigestion 536.8
045 ☐ Ulcerative Colitis 556.9
046 ☐ Depression 311
047 ☐ Diabetes Mellitus 250.0
030 ☐ Diabetes Type I 250.01
031 ☐ Diabetes Type II 250.02
029 ☐ Hyperglycemia [high blood sugar] 790.29
048 ☐ Hypoglycemia [low blood sugar] 251.2
049 ☐ Dizziness/Balance Problem 780.4
050 ☐ Ear Infection 381.4
051 ☐ Epstein Barr 075
052 ☐ Eye Problems 379.91
053 ☐ Cataracts 366.9
054 ☐ Glaucoma 365.9
055 ☐ Macular Degeneration 362.50
056 ☐ Fever 780.6
057 ☐ Fibromyalgia 729.1
058 ☐ Gallbladder Disorder 575.9
059 ☐ Gout 274.9
060 ☐ Headaches 784.0
061 ☐ Hearing Loss 389.9
062 ☐ Infertility, male 606.9
064 ☐ Liver Disease 571.9
- 065 ☐ Hepatitis 573.3
- 066 ☐ Hepatitis B 070.30

067 ☐ Hepatitis C 070.51
068 ☐ Kidney Disorder 593.9 or Bladder Disorder 596.9
063 ☐ Prostate Disorder 602.9
069 ☐ Hyperthyroidism 242.90
070 ☐ Hypothyroidism 244.9
071 ☐ Systemic Lupus 710.0
072 ☐ Infertility, female 628.9
073 ☐ Interstitial Cystitis 595.1
074 ☐ Irregular Menstrual Cycle 626.4
075 ☐ Menopausal Symptoms 627.2
076 ☐ Hot Flashes 627.2
077 ☐ Mental Disorder 300.9
078 ☐ Insomnia 780.52
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores 528.2
081 ☐ Overweight 278.02
082 ☐ Underweight 783.22
083 ☐ Sexual Disorder 302.89
084 ☐ Spinal Problems 724.9
085 ☐ Obesity 278.00
086 ☐ GERD 530.81
087 ☐ HIV 042
088 ☐ Crohn's Disease 555.9
089 ☐ Irritable Bowel Syndrome 564.1
092 ☐ Normal Pregnancy v22.2
093 ☐ Shingles 053.9
140 ☐ Migraines 346.90
141 ☐ Rheumatoid Arthritis 714.0
142 ☐ Non-Systemic Lupus 695.4
143 ☐ Multiple Sclerosis 340
144 ☐ ALS Lou Gerigs disease 335.20
145 ☐ Polymyalgia Rheumatica 725

146 ▢ Scleroderma 710.1
171 ▢ Goiter 240.9
178 ▢ Raynaud's Syndrome 433.8
179 ▢ Hemochomatosis 275.0
180 ▢ Thalassemia 282.49
181 ▢ Brain aneurysm 431

If necessary, please state your most significant concern…

________________________________________

________________________________________

## General Health

100 ▢ Fingernail base is pink
101 ▢ Fingernail base is purple
102 ▢ Fingernails have ridges or white spots
103 ▢ Fingernails are soft
104 ▢ Fingernails are splitting
105 ▢ Fingernails peel
106 ▢ Pale fingernail beds
107 ▢ Blacks out easily
108 ▢ Balance problems
109 ▢ Difficulty walking
110 ▢ Has tattoos
111 ▢ Brittle hair
112 ▢ Dry hair
113 ▢ Thin hair
114 ▢ Hair loss
115 ▢ Drinks alcoholic beverages daily
116 ▢ Drinks less than 8 glasses of water per day
117 ▢ Currently on Chemotherapy
118 ▢ Currently on radiation treatment
148 ▢ Had radiation therapy in the last year
149 ▢ Had chemotherapy in the last year
119 ▢ Had chemotherapy in the past
120 ▢ Has had radiation treatments in the past
121 ▢ Gained over 20 lbs in the last 12 months
122 ▢ Somewhat Overweight
123 ▢ Somewhat Underweight
124 ▢ Unexplained weight loss of over 20lbs within the last 4 months
125 ▢ Energy level is worse than it was 5 years ago
127 ▢ Sleeps less than 6 hours per night
128 ▢ Unable to recall dreams the next day
129 ▢ Sensitive to chemicals, paint, fumes, cologne
130 ▢ Had blood transfusion in the past
131 ▢ Had transplant in the past
138 ▢ Takes anti-rejection drugs
132 ▢ Had a major accident or injury
137 ▢ Sleep Apnea
139 ▢ Toxic chemical exposure
175 ▢ Has been out of the country recently
176 ▢ Had childhood vaccines
177 ▢ Had a vaccine in the last 12 months
147 ▢ Had a flu shot last year
182 ▢ Had a pneumonia vaccine last year
183 ▢ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:
184 ▢ Cancer
185 ▢ Heart Disease
186 ▢ Diabetes
187 ▢ Alcoholism
188 ▢ Depression
189 ▢ Obesity

## Lifestyle Habits

380 ▢ Drinks beverages from a can
370 ▢ Drinks alcohol
371 ▢ Drinks caffeinated coffee
372 ▢ Drinks caffeinated pop/soda
373 ▢ Drinks caffeinated tea
374 ▢ Drinks decaffeinated coffee
375 ▢ Drinks decaffeinated pop/soda
376 ▢ Drinks decaffeinated tea
377 ▢ Drinks more than 3 cups of coffee per day
378 ▢ Drinks more than 3 cups of tea per day
388 ▢ Drinks diet pop/soda
379 ▢ Drinks 1 or more pop/sodas per day

I had 4 alcoholic drinks in one day:
172 ▢ never
173 ▢ more than 3 months ago
174 ▢ less than 3 months ago

381 ▢ Has more than 5 alcoholic drinks per week
391 ▢ Craves sugar / starches
382 ▢ Currently smokes
383 ▢ Quit smoking in the last 5 years
384 ▢ Smoked for more than 5 years
385 ▢ Smokes more than 1 pack per day
126 ▢ Rarely exercises
133 ▢ Regularly exercises
386 ▢ Takes Vitamins
134 ▢ Vegetarian
135 ▢ Eats no red meat
136 ▢ Eats no meat, no dairy
387 ▢ Frequent use of artificial sweeteners
389 ▢ Anorexia
390 ▢ Bulimic

## Surgeries

- 700 ▢ Tonsillectomy and/or Adenoids
- 701 ▢ Appendix
- 702 ▢ Gallbladder
- 703 ▢ Thyroid
- 715 ▢ Radiated thyroid
- 708 ▢ Cancer
- 704 ▢ Hysterectomy, complete
- 705 ▢ Hysterectomy, partial
- 706 ▢ Tubal ligation
- 707 ▢ Breast implants
- 709 ▢ Coronary by-pass
- 710 ▢ Spinal surgery
- 711 ▢ Extremity surgery
- 712 ▢ Hip replacement
- 713 ▢ Knee replacement
- 714 ▢ Splenectomy
- 716 ▢ Cataract surgery
- 717 ▢ Hemorroidectomy

## Gastrointestinal

- 265 ▢ 4-5 bowel movements per week
- 266 ▢ 3 or less bowel movements per week
- 267 ▢ 6 or more bowel movements per week
- 268 ▢ Black tarry stools
- 269 ▢ Pale or yellow colored stool
- 270 ▢ Blood stools
- 271 ▢ Constipation
- 272 ▢ Hemorrhoids
- 273 ▢ Loose bowel movements
- 274 ▢ Frequent diarrhea
- 275 ▢ Frequent nausea
- 276 ▢ Frequent vomiting
- 277 ▢ Abdominal gas
- 278 ▢ Belching and burping after eating
- 279 ▢ Bloated after eating
- 280 ▢ Severe abdominal pains
- 281 ▢ Stomach ulcers
- 282 ▢ Uses digestive aids
- 283 ▢ Uses laxatives
- 284 ▢ Immediate indigestion upon eating
- 285 ▢ Indigestion in 2 hours or more after meals
- 286 ▢ Indigestion within 1 hour after meals
- 287 ▢ Difficulty swallowing
- 288 ▢ Eating relieves fatigue
- 289 ▢ Eats when nervous
- 290 ▢ Excessive hunger
- 291 ▢ Poor appetite
- 292 ▢ Experiences fainting spells when hungry
- 293 ▢ Feels shaky when hungry
- 294 ▢ Frequently drowsy after eating a meal
- 295 ▢ Gall bladder disease
- 296 ▢ Has had intestinal worms
- 297 ▢ Reflux/Hiatal hernia
- 298 ▢ Liver disease
- 299 ▢ Irritable Bowel Syndrome
- 300 ▢ Diverticulitis
- 301 ▢ Diverticulosis

## Respiratory

- 485 ▢ Catches severe colds
- 486 ▢ Chronic chest condition
- 487 ▢ Chronic cough
- 488 ▢ Constant runny nose
- 489 ▢ COPD
- 490 ▢ Difficulty breathing
- 491 ▢ Frequent colds
- 492 ▢ Frequent nose bleeds
- 493 ▢ Frequent sinus infections
- 494 ▢ Frequent stuffy nose
- 495 ▢ Hay fever
- 496 ▢ Nasal polyps
- 497 ▢ Night sweats
- 498 ▢ Post nasal drip
- 499 ▢ Sneezing spells
- 500 ▢ Spits up blood
- 501 ▢ Spits up phlegm
- 502 ▢ Wheezes

## Mouth and Throat

- 400 ▢ Bad breath
- 401 ▢ Bitter taste in the mouth in the morning
- 402 ▢ Dry mouth
- 403 ▢ Excessive saliva
- 404 ▢ Sores or cracks in the corners of the mouth
- 405 ▢ Glands often swell
- 406 ▢ Frequent canker sores
- 407 ▢ Frequent fever blisters
- 408 ▢ Frequent sore throats
- 409 ▢ Frequently has a sore tongue
- 410 ▢ Sore gums
- 411 ▢ Swollen gums
- 412 ▢ Swollen tongue
- 413 ▢ Tongue burns
- 414 ▢ Tongue has grooves or fissures
- 415 ▢ Tongue is coated
- 416 ▢ Gums bleed when brushing teeth
- 417 ▢ Toothaches
- 418 ▢ Amalgam dental fillings
- 420 ▢ Other dental fillings (gold,composite, etc)
- 419 ▢ Has had root canal(s)

## Endocrine

- 245 ☐ Coarse hair
- 246 ☐ Coarse skin
- 247 ☐ Diabetic
- 248 ☐ Excessive thirst
- 249 ☐ Frequently feels cold
- 250 ☐ Frequently feels hot
- 251 ☐ Gets lightheaded when standing quickly
- 252 ☐ Heals slowly
- 253 ☐ Unusually jumpy or nervous
- 254 ☐ Unusually tired most of the time

## Cardiovascular

- 190 ☐ Cold feet
- 191 ☐ Cold hands
- 192 ☐ Experiences shortness of breath while sitting still
- 193 ☐ Heart skips beats
- 194 ☐ Tendency of High blood pressure
- 195 ☐ Leg cramps during bedtime
- 196 ☐ Leg cramps during daytime
- 197 ☐ Low blood pressure at times
- 198 ☐ Pain in leg/hips when walking
- 199 ☐ Frequent swollen ankles
- 200 ☐ Pains in the heart or chest
- 201 ☐ Spells of rapid heart rate
- 202 ☐ Troubled with blood clots
- 203 ☐ Unusually slow pulse rate
- 204 ☐ Varicose veins
- 205 ☐ Heart palpitations

## Skin

- 520 ☐ Bruises easily
- 521 ☐ Excessive perspiration
- 522 ☐ Frequent goose bumps
- 523 ☐ Has acne
- 524 ☐ Has Psoriasis
- 525 ☐ Hives
- 526 ☐ Itchy skin
- 527 ☐ Problems with Eczema
- 528 ☐ Has moles which are changing in size and/or color
- 530 ☐ Skin is rough, especially on the back of the arms
- 529 ☐ Skin eruptions
- 531 ☐ Skin is tender
- 532 ☐ Sores that heal slowly
- 533 ☐ Troubled with boils
- 534 ☐ Dry skin

## Ears

- 220 ☐ Discharge from ears
- 221 ☐ Hard of hearing
- 222 ☐ Punctured ear drum
- 223 ☐ Recurrent ear infection
- 224 ☐ Ringing or noises in the ears
- 225 ☐ Tinnitus

## Eyes

- 320 ☐ Bloodshot eyes
- 321 ☐ Blurred vision
- 322 ☐ Cross eyes
- 323 ☐ Eye pain
- 324 ☐ Eyes feel gritty
- 325 ☐ Eyes watery
- 326 ☐ Mild Glaucoma
- 327 ☐ Far sighted
- 328 ☐ Developing cataracts
- 329 ☐ Mild Macular degeneration
- 330 ☐ Itchy eyes
- 331 ☐ Near sighted
- 332 ☐ Dry Eyes

## Feet

- 350 ☐ Corns
- 351 ☐ Frequent foot cramps
- 352 ☐ Heel spurs
- 353 ☐ Painful feet
- 354 ☐ Plantar warts
- 355 ☐ Swelling in the feet and/or ankles
- 356 ☐ Plantar fascitis
- 357 ☐ Fungal Infection

## Neuromuscular

- 440 ☐ Bites nails
- 441 ☐ Frequent muscle soreness
- 442 ☐ Muscle spasms
- 443 ☐ Muscle weakness
- 444 ☐ Tremors
- 445 ☐ Frequent headaches
- 446 ☐ Often dizzy
- 447 ☐ Frequently feels faint
- 448 ☐ Has Epilepsy
- 449 ☐ Has motion sickness
- 450 ☐ Has Osteoarthritis
- 451 ☐ Has Rheumatism
- 452 ☐ Rheumatoid Arthritis
- 453 ☐ Joint stiffness in the morning
- 454 ☐ Swollen joints
- 455 ☐ Leg pain at rest
- 456 ☐ Spinal curvature
- 457 ☐ Low back pain
- 458 ☐ Neck pain
- 459 ☐ Pain between the shoulders
- 460 ☐ Shoulder/arm pain
- 461 ☐ Numbness/tingling in the body
- 462 ☐ Sleep walks
- 463 ☐ Stutters or stammers
- 464 ☐ Nerve pain

## Behavior Patterns

150 ▢ Afraid to eat anywhere except home
151 ▢ Always needs someone to advise
152 ▢ Cries often
153 ▢ Difficulty concentrating
154 ▢ Difficulty falling asleep
155 ▢ Difficulty staying asleep
156 ▢ Easily angered
157 ▢ Feelings are easily hurt
158 ▢ Frequently becomes scared for no reason
159 ▢ Frequently miserable or blue
160 ▢ Has to be on guard even with friends
161 ▢ Often annoyed by people
162 ▢ Recurrent bad dreams
163 ▢ Sometimes wishes to be dead or away from it all
164 ▢ Upset by criticism
165 ▢ Poor memory
166 ▢ Scared to be alone
167 ▢ Strange people or places cause fear
168 ▢ Under considerable emotional stress
169 ▢ Unhappy when other are happy
170 ▢ Brain fog

## Urinary

555 ▢ Urinates more than 2 times per night
556 ▢ Bed wetting
557 ▢ Blood in the urine
558 ▢ Difficulty starting urination
559 ▢ Painful urination
560 ▢ Frequent urination
561 ▢ Troubled by urgent urination
562 ▢ Incontinence when sneezing or laughing
563 ▢ Loses bladder control
564 ▢ Frequent bladder infections
565 ▢ Frequent kidney infections
566 ▢ Kidney stones

## Men Only

585 ▢ Difficulty completing intercourse
586 ▢ Difficulty getting or keeping an erection
587 ▢ Discharge from the urethra
588 ▢ Had a vasectomy
589 ▢ Had difficulty fathering children
590 ▢ Lumps in the testicles
591 ▢ Painful genitals
592 ▢ Prostate troubles
593 ▢ Sores on external genitalia
594 ▢ Herpes
595 ▢ Sexual diseases

# Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

## NUTRITIONAL SUPPLEMENTS

***Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.***

| VITAMIN/HOW MUCH/BRAND | HOW LONG? |
|---|---|
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## Medications

***Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.***

| DRUG | PRESCRIBED FOR: | HOW LONG |
|---|---|---|
| | | |
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***Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.***

| DRUG | PRESCRIBED FOR: | HOW LONG |
|---|---|---|
| | | |
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