

Have you had or do you now have any of the following symptoms. Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now	Past		Now	Past
	N	P		N	P
Headaches _____ Frequency	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in Arms	_____	_____	Colitis	_____	_____
Weakness in Legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Lights Bother Eye	_____	_____	Shoulder Pain	_____	_____
Loss of Memory	_____	_____	Swelling Joints	_____	_____
Ears Ring	_____	_____	Knee Pain	_____	_____
Face Flushed	_____	_____	Hayfever	_____	_____
Buzzing in Ears	_____	_____	Menstrual Difficulties	_____	_____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE _____