Patient Last Name, First Initial:____

Please mark each of the following symptoms: 1 If you have the problem now/recently 2 If you've had the problem in the past.

General
- ___ Headache
- ___ Fever
- ___ Chills
- ___ Night Sweats
- ___ Fainting
- ___ Dizziness
- ___ Convulsions
- ___ Loss of sleep
- ___ Fatigue
- ___ Nervousness
- ___ Loss of weight
- ___ Numbness/pain arms/legs/hands
- ___ Allergy
- ___ Wheezing
- ___ Neuralgia

Gastro-Intestinal
- ___ Poor appetite
- ___ Poor digestion
- ___ Excessive hunger
- ___ Belching or gas
- ___ Nausea
- ___ Vomiting
- ___ Vomiting blood
- ___ Pain over stomach
- ___ Constipation
- ___ Diarrhea
- ___ Colon trouble
- ___ Hemorrhoids
- ___ Liver trouble
- ___ Jaundice
- ___ Gall bladder trouble

Respiratory
- ___ Chronic cough
- ___ Spitting blood
- ___ Phlegm
- ___ Chest pain
- ___ Difficulty breathing

Genio-Urinary
- ___ Frequent urination
- ___ Painful urination
- ___ Blood in urine
- ___ Kidney infection
- ___ Bed wetting
- ___ Inability to control urine
- ___ Prostrate trouble

Eye/Ear/Nose/Throat
- ___ Poor vision
- ___ Pain in eyes
- ___ Deafness
- ___ Earache
- ___ Ear noises
- ___ Nose bleeds
- ___ Sore throat
- ___ Hay fever
- ___ Asthma
- ___ Frequent colds
- ___ Enlarged thyroid
- ___ Tonsillitis
- ___ Sinus trouble

Muscles/Joints
- ___ Weakness
- ___ Twitching
- ___ Stiff neck
- ___ Backache
- ___ Swollen joints
- ___ Tremors
- ___ Foot trouble
- ___ Painful tailbone
- ___ Pain between shoulders
- ___ Spinal curvature
- ___ Hernia

Cardio-Vascular
- ___ Rapid heartbeat
- ___ Slow heartbeat
- ___ High blood pressure
- ___ Low blood pressure
- ___ Pain over heart
- ___ Heart trouble
- ___ Ankle swelling
- ___ Poor circulation
- ___ Varicose veins
- ___ Stroke
- ___ Cold hands/feet

Skin/Allergies
- ___ Skin eruptions
- ___ Itching
- ___ Bruising easily
- ___ Dryness
- ___ Boils
- ___ Hives
- ___ Sensitive skin
- ___ Eczema
- ___ Psoriasis

Women Only
- ___ Painful periods
- ___ Excessive flow
- ___ Irregular cycles
- ___ Hot flashes
- ___ Cramps
- ___ Vaginal discharge
- ___ Miscarriage
- ___ PMS
- ___ Pregnant

Date of last PAP: ___/___/____

Please mark **(1 or 2, as above)** if you've had any of the following conditions:

- ___ Addiction
- ___ Alcoholism
- ___ Anemia
- ___ Arthritis
- ___ Cancer
- Cancer Type_____________
- ___ Chicken pox/Shingles
- ___ Chronic pain
- ___ Chronic sinusitis
- ___ Depression/Anxiety
- ___ Diabetes Type I or II
- ___ Eating disorder
- ___ Mono
- ___ Epilepsy
- ___ Fibroid tissue
- ___ Gall bladder disease
- ___ Gout
- ___ Heart disease
- ___ Heshimotos
- ___ High Blood Pressure
- ___ High Cholesterol
- ___ Influenza
- ___ Low Back Pain
- ___ Measles
- ___ Menopause
- ___ Mercury fillings
- ___ Migraines
- ___ Mumps
- ___ Orthodontics
- ___ Ovarian cysts
- ___ Pneumonia
- ___ Polio
- ___ Rheumatic fever
- ___ Rheumatoid Arthritis
- ___ Root canal
- ___ Thyroid Disease
- ___ Thyroid Goiter
- ___ Toxic exposure
- ___ Tuberculosis
- ___ Vaccinations
- ___ Weight gain
- ___ Whooping cough

If other, please explain: