

SYMPTOM SURVEY

Please mark all symptoms, past and present

- Past Now MUSCLES & BONES**
- Low Back Pain
 - Pain between shoulders
 - Head/neck problems
 - Arm problems
 - Leg problems
 - Foot/ankle problems
 - Jaw pain/clicking
 - Hand/wrist problems
 - Hip problems
 - Muscles weak/sore
 - Shoulder problems
 - Walking problems
 - Knee problems
 - Arthritis pain
 - Muscle cramps
 - Joint pain
 - Joint swelling
 - Joint popping
 - Joint grinding
 - Loss of joint motion

- Past Now NERVOUS SYSTEMS**
- Numbness/tingling
 - Fatigue
 - Dizziness
 - Fainting
 - Headaches
 - Cold feet/hands
 - Confusion
 - Irritability/tension
 - Depression
 - Crying spells
 - Loss of feeling
 - Loss of balance
 - Loss of coordination
 - Convulsions
 - Paralysis

- Past Now HEART & LUNGS**
- Chest pains
 - Shortness of breath
 - Difficult breathing
 - Persistent cough
 - Coughing phlegm
 - Coughing blood
 - Rapid heartbeat
 - Blood pressure problems
 - Heart problems
 - Lung problems
 - Varicose veins
 - Hiatal hernia

- Past Now EYES, EARS, NOSE & THROAT**
- Wear glasses/contacts
 - Ear pain
 - Ear noises/ringing
 - Dental problems
 - Throat problems
 - Thyroid problems
 - Sinus problems
 - Nasal problems
 - Nose bleeds
 - Last eye exam
 - Light bothers eyes
 - Halos around lights
 - Spots in eyes
 - Blurred vision
 - Double vision
 - Loss of hearing
 - Ear infections
 - Allergies
 - Frequent colds
 - Loss of smell/taste
 - Hoarseness
 - Gagging
 - Choking
 - Difficulty swallowing
 - Gums sore/bleeding

- Past Now URINARY TRACT**
- Bladder problems
 - Pain urinating
 - Difficulty urinating
 - Change in frequency of urination
 - Discolored urine
 - Prostate problems

- Past Now STOMACHS & INTESTINES**
- Poor appetite
 - Excessive hunger
 - Crave sweets
 - Excessive thirst
 - Nausea
 - Belching
 - Vomiting
 - Indigestion/heartburn
 - Abdominal pain
 - Diarrhea
 - Gas
 - Constipation
 - Black stool
 - Hemorrhoids
 - Liver problems
 - Gall bladder problems
 - Overweight
 - Underweight

- Past Now GENERAL**
- Fatigue
 - Sleeping difficulty
 - Recurrent colds/infections
 - Skin changes
 - Lumps/lymph glands swelling
 - Forgetfulness
 - Nervousness
 - Bruise easily
 - Asthma

- Past Now FEMALE**
- Irregular bleeding
 - Genital pain
 - Breast pain
 - Lumps on breast
 - Menstrual cramps
 - Hot flashes
 - Irregular periods
 - Recurrent infections
 - Problem pregnancies
 - Hysterectomy
 - Discharge

Date of last period: _____
 Breast exam: _____
 Self exam: _____
 Is there any possibility you're pregnant? YES NO

- Past Now CHILDREN**
- Learning difficulties
 - Over active
 - Coordination problems
 - Recurrent infection
 - Sensitives to food or medications

OTHER

MISCELLANEOUS

What medications/vitamins are you taking?

Any other drugs? Even over the counter?

Do you sleep primarily on your?	BACK	SIDE	STOMACH	Normal hours of sleep?			
Do you have a regular exercise program?	YES		NO	What? How often?			
Do you have a well-balanced diet of variety of foods?	YES		NO				
Please rate your stress level: (1=no stress, 10=excessive stress)			PERSONAL LIFE	JOB			
Does your employment require	SITTING	WRITING	TYPING	STANDING	LIFTING	BENDING	WALKING
	DRIVING						

FAMILY HISTORY (Answer the following with F=Father, M=Mother, B=Brother, S=Sister, O=Other)

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Other, describe _____ | | |

NOTES

I declare that I have answered the above truthfully and to the best of my knowledge.

Patient's Signature

Date