Short Intake Form Part 2

MEDICAL HISTORY

Please Circle | **Explain**

•	Headaches	Yes	No
•	Dizziness	Yes	No
•	Blurred Vision	Yes	No
•	Buzz/Ring Ears	Yes	No
•	Depression	Yes	No
•	Nervousness	Yes	No
•	Difficulty Sleeping	Yes	No
•	Loss of Energy	Yes	No
•	Sinuses	Yes	No
•	Neck Pain/Stiff	Yes	No
•	Shoulder Problems	Yes	No
•	Upper Back	Yes	No
•	Mid Back	Yes	No
•	Chest Pain	Yes	No
•	Stomach	Yes	No
•	Constipation	Yes	No
•	Liver	Yes	No
•	Kidney	Yes	No
•	Bladder	Yes	No
•	Low Back	Yes	No
•	Hips	Yes	No
•	Leg Pain/Cramps	Yes	No
•	Poor Circulation	Yes	No
•	Osteoporosis	Yes	No
•	Hi/Low Blood Pressure	Yes	No

ACCIDENT HISTORY

Date of Accident/Injury:

List major complaints(s):

When did you first notice this?

Is it worse, AM/PM?

Any radiation of pain into arms or legs?

Is pain sharp or dull pain?

Is pain constant or does it come and go?

Other Doctor's seen for condition?

Did anyone recommend surgery?

Any medication(s) taken for this condition?

Are you pregnant? yes/no

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