Confidential Injury Questionnaire

Patient's Name:			Date:
Please complete section A J	first. For a job-related injury, compl	ete section B. For an auto	omobile injury, complete section C
SECTION A: (please che	ck symptoms you have noticed sinc	ce the accident)	
☐ Headache	☐ Dizziness	☐ Loss of Memory	☐ Feet Cold
☐ Neck Pain	☐ Head Seem Too Heavy	☐ Ears Ring	☐ Hands Cold
☐ Neck Stiff	☐ Pins & Needles in Arms	☐ Face Flushed	☐ Stomach Upset
☐ Sleeping Problems	☐ Pins & Needles in Legs	☐ Buzzing in Ears	☐ Constipation
☐ Back Pains	☐ Numbness in Fingers	☐ Loss of Balance	□ Cold Sweats
☐ Nervousness	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Tension	☐ Fatigue	☐ Loss of Smell	☐ Other Symptoms:
☐ Irritability	☐ Depression	☐ Loss of Taste	
☐ Chest Pain	☐ Light Bothers Eyes	 Diarrhea 	
Other Symptoms (cont	'd):		
Did you go to the Emergence	y Room? Yes No		Were you hospitalized? ☐ Yes ☐ No
If yes, Name of Hospital			
Other Doctors Seen:			
		- 1	
Have you been contacted by	k? ☐ Yes ☐ No If so, please list dates an insurance adjuster or company repres vising you on this case? ☐ Yes ☐ No		Yes □ No
Have you been contacted by Do you have an attorney adv	an insurance adjuster or company repres	entative about this claim?	Yes □ No
Have you been contacted by Do you have an attorney adv SECTION B: (please cor	an insurance adjuster or company repres vising you on this case? I Yes I No nplete ONLY if the injury is JOB-	entative about this claim?	Yes □ No
Have you been contacted by Do you have an attorney adv SECTION B: (please cor Occupation:	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties:	entative about this claim?	Yes □ No
Have you been contacted by Do you have an attorney adv SECTION B: (please cor Occupation: Date of Injury: Description of Accident:	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location:	entative about this claim? RELATED)	Yes □ No
Have you been contacted by Do you have an attorney adv SECTION B: (please corrections) Occupation: Date of Injury: Description of Accident: Workman's Compensation Car	an insurance adjuster or company repres rising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location:	entative about this claim? RELATED) Insurance Company Case #:	Yes □ No
Have you been contacted by Do you have an attorney adv SECTION B: (please cor Occupation: Date of Injury: Description of Accident: Workman's Compensation Callisurance Co.:	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location:	entative about this claim? RELATED) Insurance Company Case #:	Yes □ No
Have you been contacted by Do you have an attorney adv SECTION B: (please cor Occupation: Date of Injury: Description of Accident: Workman's Compensation Callisurance Co.: Employer:	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location:	entative about this claim? RELATED) Insurance Company Case #:	
Have you been contacted by Do you have an attorney advectory SECTION B: (please confidence) Occupation: Date of Injury: Description of Accident: Workman's Compensation Callingurance Co.: Employer: SECTION C: (please confidence)	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location: Address: Address:	entative about this claim? RELATED) Insurance Company Case #:	
Have you been contacted by Do you have an attorney adversariance Co.: Employer: Bate of Injury: Workman's Compensation Called Insurance Co.: Employer: SECTION C: (please contacted by Date of Injury: How did accident occur? Accident	an insurance adjuster or company repres rising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location: Address: Address: mplete ONLY if the injury is due to Time: Location: uto Collision Other (please describe):	entative about this claim? RELATED) Insurance Company Case #:	
Have you been contacted by Do you have an attorney adv SECTION B: (please cor Occupation: Date of Injury: Description of Accident: Workman's Compensation Callusurance Co.: Employer: SECTION C: (please cor Date of Injury: How did accident occur? Accident occurs o	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location: Address: Address: Address: Inplete ONLY if the injury is due to Time: Location: Ito Collision Other (please describe): Driver Passenger Pedestrian	entative about this claim? RELATED) Insurance Company Case #:	
Have you been contacted by Do you have an attorney adv SECTION B: (please cor Occupation: Date of Injury: Description of Accident: Workman's Compensation Callasurance Co.: Employer: SECTION C: (please cor Date of Injury: How did accident occur? Accident occur? Accident occur? Accident occur? If auto accident, were you: If collision, were you struck from	an insurance adjuster or company repres rising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location: Address: Address: Address: Time: Location: Other (please describe): Driver Passenger Pedestrian m: Behind Right Side Left Side	entative about this claim? RELATED) Insurance Company Case #: o an AUTO ACCIDEN Front Auto was Parked	T)
Have you been contacted by Do you have an attorney adversariance Concupation: Date of Injury: Description of Accident: Workman's Compensation Callusurance Co.: Employer: SECTION C: (please conducted Date of Injury: How did accident occur? And If auto accident, were you:	an insurance adjuster or company repres vising you on this case? Yes No nplete ONLY if the injury is JOB- Duties: Time: Location: Address: Address: Address: Inplete ONLY if the injury is due to Time: Location: Ito Collision Other (please describe): Driver Passenger Pedestrian	entative about this claim? RELATED) Insurance Company Case #: o an AUTO ACCIDEN Front	T)

Confidential Patient Questionnaire

Welcome to our office. Please provide as much information as possible, the better to help us understand your background and condition. In accordance with the law, all information provided will be held in the strictest confidence.

PLEASE PRINT:				
Name			Birth Date	Age
Address		City	State	Zip
Home Phone	Cell P	Phone	Email A	ddress
Work Phone		Occupati	ion	
Marital Status: ☐ Single	☐ Married	□ Widowed	☐ Divorced	
Whom may we thank for re In case of emergency, who		ct?		
Name	Relation		Phone Cell P	Phone
Is this condition due to a w				
Is this condition due to an		nt: U Yes U.	NO	
IMPORTANT QUESTION Are you pregnant or is ther		nat you might be	pregnant? 🗆 Yes 🗆	l No
I understand and agree that ance company(ies). I further & Dr. Joyce's Office will be services rendered to me are cl	understand and agre credited to my accoun	ee that any amoun t upon receipt. Ho	it authorized to be paid d wever, I clearly understand	irectly to Dr. Mary's I and agree that all
Patient's Signature	Date	Guardia	n or Spouse's Signature	e Date

(516) 742-2442 Fax: 516-742-6807

Patient Health Questionnaire

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Patient Name	Da	ate	lomal Use Only
Describe your symptoms, when they started and ho	w they began:		
indicate on the pictures below where you have pain	or other symptoms. We		
	WH HO	w often do you experience y 1-Constantly (76-100% of the 2-Frequently (51-75% of the 3-Occasionally (26-50% of the 4-Intermittently (0-25% of the nat describes the nature of y Sharp O Shooting Dull ache O Burning Numb O Tingling w are your symptoms chang 1-Getting Better 2-Not Changing 3-Getting Worse	ne day) e day) the day) our symptoms? O O gling?
	orst: 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	Unbeerable O O O 9 10
How do your symptoms affect your ability to perfor	m dally activities?	. • • • •	0 10
O 0 0 1 0 2 0 3 0 4 No compleints Mild, forgotten with activity with activity	○ 5 ○ 6 ieres Limiting, prevents		10 Severe, no activity possible
What activities make your symptoms worse:			
What activities make your symptoms better:			
Who have you seen for your symptoms? When and what treatment?	O 1-No One O 2-Other Chiropractor	 O 3-Medical Doctor O 4-Physical Therapist 	O 5-Other
What tests have you had for your symptoms? Have you had similar symptoms in the past?	**************************************	T Scan O 3-MRI Scan	O 4-Other
if you have received treatment in the past for the same or similar symptoms, who did you see?	O 1-Yes O 2-No O 1-This Office O 2-Other Chiropractor	 ○ 3-Medical Doctor ○ 4-Physical Therapist 	O 5-Other
What is your occupation?	O 1-Professional/Executivo 2-White Collar/Secretario 3-Tradesperson	ve O 4-Laborer rial O 5-Homemaker O 6-FT Student	O 7-Retired O 8-Other
If you are not retired, a homemaker, or a student, what is your current work status?	O 1-Full-time O 2-Part-time	O 3-Self-employed O 4-Unemployed	O 5-Off work O 6-Other
Potlant Simoston			n occuming again
Patient Signature		Date	

Neck Disability Index Questionnaire

all	ent Name: To	oday	's Date:
rlea	se complete this questionaire by circling one answer in each a trouble has affected your ability to manage in everyday life	secti	on. It is designed to give us information as to how your
			A service and a
	Pain Intensity		Concentration
)	I have no pain at the moment	0	I can concentrate fully with no difficulty
	The pain is very mild at the moment	1	I can concentrate fully with slight difficulty
	The pain is moderate at the moment	2	I have a fair degree of concentrating
	The pain is fairly severe at the moment	3	I have a lot of difficulty concentration
	The pain is severe at the moment	4	I have a great deal of difficulty in concentrating
	The pain is worst imaginable at the moment	5	I cannot concentrate at all
	Lifting		Work
)	I can lift heavy weights without extra pain	Q	I can do as much work as I want
	I can lift heavy weight, but it gives me extra pain	1	I can only do my usual work but no more
	Pain prevents me from lifting heavy weights off the floor,	2	I can do most of my usual work, but no more
	but I can lift heavy weights off a table	3	I cannot do my usual work
3	Pain prevents me from lifting heavy weights off the floor,	4	I can hardly do any work at all
38: 3	but I can lift moderate wieghts off a table.	5	I can't hardly do any work at all
4	I can lift only very light weights		A STANDARD CONTRACTOR OF THE STANDARD CONTRACTOR
	I cannot lift and/or carry anything at all		Sleeping
	Headaches	0	I have no trouble sleeping
		1	My sleep is slightly disturbed (less than 1hr sleepless
0	I have no headaches at all	2	My sleep is mildly disturbed (1-2 hr's sleepless)
i	I have no headaches at all	3	My sleep is moderately disturbed (2-3 hr's sleepless)
2	I have moderate headaches that come infrequently	4	My sleep is greatly disturbed (3-5 hr's sleepless)
3	I have moderate headaches which come frequently	5	My sleep is completely disturbed (5-7 hr's sleepless)
4	I have severe headaches which come frequently	7	
5	I have headaches all the time		
	Burney (March 1997)		Driving
	Personal Care (Washing, Dressing)	0	I can drive my car without neck pain
_	I am last of an averall named by without extra pain	1	I can drive as long as I want with slight pain
0	I can look after myself normally without extra pain I can look after myself normally but it causes extra pain	2	
1	It is painful to look after myself & I am slow & careful	3	I can't drive as long as I want due to moderate pain
	I need some help everyday in most aspects of self care	4	I can hardly drive at all because of severe neck pain
3	I need help everyday in most aspects of self care	5.	[1921 NOTO HERMAN HERMAN HERMAN NOTO NOTO HERMAN H
5	I do not get dressed and stay in bed because of the difficulty		tour various our action
	Reading		Recreation
0	I can read as much as I want with no pain in my neck	0	I engage in all my recreation activities with no pain
1	I can read as much as I want with slight pain in my neck	1	I can engage in all my activities with slight pain
2	I can read as much as I want with moderate pain in my neck	2	I engage in most of my recreation activities but not al
3	I can't read as much as I want because of moderate pain		because of neck pain
4	I can hardly read at all because of severe pain in my neck	3	- 1 a in the contract water
5	I cannot read at all	4 5	I engage in hardly any activities because of neck pair
^	a seeds from 0 to 10 with 0 being so sain & 10 being the w	hret	nein mark on the scale below your current pain level
0	n a scale from 0 to 10, with 0 being no pain & 10 being the we	1	6 7 8 9 10 Worst Imaginable Pain

Patient Health Questionnaire

8 1		100	1
1	1 1	 1	1

Patient Name		Date		Internet Use Only
Describe your symptoms, when they started and ho	w they began;			
Indicate on the pictures below where you have pain	or other symptoms	How offer o		
	or other symptoms	O 1-Cons O 2-Frequ O 3-Occa O 4-Interr What descrit O Sharp O Dull act O Numb How are you O 1-Gettl O 2-Not 0	he OBurning OTIngling ur symptoms char ng Better	the day) ne day) f the day) the day) your symptoms?
How bad are your symptoms at their:	None			Unbearable
	orst: 0 0 0	00	0 0 0	000
How do your symptoms affect your ability to make	0 1 2	3 4 5	6 7 8	9 10
How do your symptoms affect your ability to perfor		0.7		(40.000)
No complaints Mild, forgotten Moderate, interfuently with activity with activity			O 8 O 9 se, preoccupied a seeking relief	○ 10 Severe, no activity possible
What activities make your symptoms worse:				,
What activities make your symptoms better:				
Who have you seen for your symptoms?	O 1-No One O 2-Other Chiropract		Medical Doctor Physical Therapist	O 5-Other
When and what treatment?				
What tests have you had for your symptoms?	O 1-Xrays O	2-CT Scan	O 3-MRI Scan	O 4-Other
Have you had similar symptoms in the past?	O 1-Yes O	2-No		
If you have received treatment in the past for the	O 1-This Office	0 3-	Medical Doctor	O 5-Other
same or similar symptoms, who did you see?	O 2-Other Chiropract	or 0 4-l	Physical Therapist	0
What is your occupation?	O 1-Professional/Exe O 2-White Collar/Sec O 3-Tradesperson	retarial 0 5-	Laborer Homemaker FT Student	O 7-Retired O 8-Other
if you are not retired, a homemaker, or a student, what is your current work status?	O 1-Full-time O 2-Part-time		Self-employed Unemployed	O 5-Off work O 6-Other
What do you hope to get from your visit/treatment: O 1-Reduce symptoms O 2-Resume/increase activity O 4-Learn how to ta		O 5-Ho	w to prevent this fro	om occurring again
Patient Signature	3	Da	te	
			· · · · · · · · · · · · · · · · · · ·	

Oswestry Disability Index Questionnaire

D.	ationts Names		Todays Date:
P	atients Name:	in ea	ch section. It is designed to give us information as to how your
	ack (or leg) trouble has affected your ability to manage i		
	,		
	Pain intensity		Walking
	,		
0	The pain comes & goes & it is very mild	0	Pain does not prevent me from walking any distance
1	The pain is mild and does not vary much	1	Pain prevents me from walking more than a mile
2	The pain comes & goes & is moderate	2	Pain prevents me from walking more than more than 1/2 mile
3	The pain is fairly severe at the moment	3	Pain prevents me from walking more than ¼ mile I can only walk using a cane or crutches
4	The pain is very severe at the moment The pain is the worst imaginable at the moment	5	I am in bed most of the time & I have to crawl to the toilet
-	The pain is the worst imaginative at the monten.	·	
	Standing		Lifting
0	I can stand as long as I want with no extra pain	0	I can lift heavy weights without extra pain
1	I can stand as long as I want but it gives me extra pain	1	I can lift heavy weights but it gives me extra pain
	Pain prevents me from standing for more than an hour	2	Pain prevents me from lifting weights off the floor but I can manage
	Pain prevents me from standing for more than 1/2 hour		if they are conveniently positioned (i.e on a table)
	Pain prevents me from standing for more than ten minutes	3	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they conviently positioned
)	Pain prevents me from standing at all	4	I can only lift very light weights
		5	I cannot lift or carry anything at all
	Class		Sleeping
	Sitting		Steeping
0	I can sit in any chair as long as I like without pain		0 My sleep is disturbed by pain
1	I can only sit in my favorite chair as long as I like		1 My sleep is slightly disturbed (less than 1hr sleepless
2			2 My sleep is mildly disturbed (1-2 hr's sleepless)
3			 My sleep is moderatly disturbed (2-3 hr's sleepless My sleep is greatly disturbed (3-5 hr's sleepless)
4	Pain prevents me from sitting more than ten minutes Pain prevents me from sitting at all		4 My sleep is greatly disturbed (3-5 hr's sleepless) 5 Pain prevents me from sleeping at all
5	rain prevents the from stiting at all		y talk province the north crooping with
	Personal Care		Traveling
	reisonal Care		
0	I can look after myself normally without any extra pain		0 I can travel anywhere without pain
	I can look after myself normally but it is painful		1 I can travel anywhere but it gives me extra pain
	It is painful to look after myself & I am slow & careful		2 Pain is bad but I manage journeys over two hours
	I need some help but manage more of my personal care		3 Pain restricts me to journeys of less than one hour 4 Pain restricts me to journeys of less than 30 minutes
4	I need help everyday in most aspects of self care I do not get dressed, wash with difficulty & stay in bed		5 Pain prevents me from traveling except to receive treatment
3	I do not get dressed, wash with difficulty & stay in bed		5 1 am prevents the from that string except to receive meaning
	Social Life		Changing Degree of Pain
			A Mountain to sould be considered better
0	My social life is normal & gives me no extra pain My social life is normal but increases the degree of pain		My pain is rapidly getting better My pain fluctuates, but overall is definitly getting better
1	Pain has no significant effect on my social life apart from		2 My pain seems to be getting better, but improvement is
4	limiting my more energetic interests (i.e dancing, etc)		slow.
3	Pain has restricted my social life & I do not go out as often		3 My pain is neither getting better nor worse
4	Pain has restricted social life to my home		4 My pain is gradually worsening
5	I have no social life because of the pain		5 My pain is rapidly worsening
(On a scale from 0 to 10, with 0 being no pain & 10 being	g the	worst pain, mark on the scale below your current pain level
1	1 2 3 4	5	6 7 8 9 10
1	No Pain		Worst Imaginable Pain
]	Patient Signature		

Patient Health	Questionnaire - page	2
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Doctors Stanature

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What is your height and weight? What is your height and weight? Weight Weight Weight Weight Weight Weight Weight Weight Ibs. For sech of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column. Past Present O Headadnes Nest Present O Head Attack Nest Pash O Head Attack O Stroke O Widek Pain O Kidney Stones O Kidney Stones O Kidney Stones O Kidney Stones O Heir Hurination O Hand Pain O Hand Pain O Hid Hip/Upper Arm Pein O Head Pain O Head Pain O Head Pain O Head Pain O Hort Pain O Hid Hip/Upper Leg Pain O Hort Freeblems O Ankelf-oot Pein O Abdominal Pain O Bith Control Pilis O Rheumatoid Arthritis O Heart Problems O Diabetes O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Ca	Patier	nt Name			Date	
For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column. Past Present O Headaches O High Blood Pressure O Diabetes O Neck Pain O Heart Attack O Excessive Thirst O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Shoulder Pain O Kidney Stones O Shoulder Pain O Kidney Stones O Elbow/Upper Arm Pain O Kidney Disorders O Hand Pain O Painful Urination O Systemic Lupus O High/Upper Leg Pain O Prostate Problems O Dermatitis/Eczema/Rash O Ankle/Foot Pain O Abdominal Pain O Bornal Weight Gain/Loss O Jaw Pain O Abdominal Pain O Bornal Weight Gain/Loss O Jaw Pain O Abdominal Pain O Bird Control Pills O Arthritis O Hepatitis O Pregnancy O Rheumatold Arthritis O Hepatitis O Cheer O Hormonal Replacement O Rheumatold Arthritis O Cheer O Cheer O Cherrhealth Problems O Muscular Incoordination O Tumor O Stroke O Dizziness O Chronic Sinusitis Date Patient Signature Date	What	type of regular exercise do ye	où perform?	○ 1-None	O 2-Light	○ 3-Moderate ○ 4-Strenuous
For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column. Past Present O Headaches O High Blood Pressure O Neck Paln O Head Atlack O Excessive Thirist O Upper Back Pain O Head Atlack O Excessive Thirist O Wipper Back Pain O Chest Pains O Stroke O Shoulder Pain O Kidney Stones O Elbowr/Upper Arm Pain O Kidney Stones O Bladder Infection O Wrist Pain O Hand Pain O	What	is your height and weight?		Height		Weight Ibs.
fryou presently have a condition listed below, place a check in the Present column. Past Present Past Present Past Present				Faet	Inches	
O Headaches O High Blood Pressure O Diabetes O Neck Pain O Heart Attack O Excessive Thirst O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Smoking/Use Tobacco Products O Low Back Pain O Kidney Stones O Drug/Alcohol Dependence O Elbow/Upper Arm Pain O Kidney Stones O Drug/Alcohol Dependence O Elbow/Upper Arm Pain O Bladder Infection O Depression O Hand Pain O Bladder Infection O Depression O Hip/Upper Leg Pain O Loss of Bladder Control O Epilepsy O Knee/Lower Leg Pain O Prostate Problems O Dermatitis/Eczema/Rash O Ankle/Foot Pain O Abnormal Weight Gain/Loss O Jaw Pain O Abnormal Weight Gain/Loss O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement O Arthritis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Liver/Gali Bladder Disorder O Muscular Incoordination O Tumor O Dizzlness O Dizzlness O Diabetes O Cancer Other Health Problems/Issues O Dizzlness O Heart Problems Diabetes Cancer Lupus O Indicate if an Immediate family member has had any of the following: O Rheumatoid Arthritis O Heart Problems Diabetes Cancer Lupus O Indicate if an Immediate family member has had any of the following: O Rheumatoid Arthritis O Heart Problems Diabetes Cancer Lupus O Indicate if an Immediate family member has had any of the following: O Rheumatoid Arthritis O Heart Problems Diabetes Cancer Lupus O Indicate if the surgical procedures you have had and times you have been hospitalized: List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:	For e	ach of the conditions listed b presently have a condition l	elow, place i sted below,	a check in the Past colu place a check in the Pre	mn if you hav sent column.	e had the condition in the past.
O Neck Pain O Heart Attack O Excessive Thirst O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Low Back Pain O Angina O Smoking/Use Tobacco Products O Shoulder Pain O Kidney Stones O Drug/Alcohol Dependence O Shoulder Pain O Kidney Stones O Drug/Alcohol Dependence O Wist Pain O Bladder Infection O Depression O Hand Pain O Painful Urination O Systemic Lupus O Hip/Upper Leg Pain O Loss of Bladder Control O Epilepsy O Knee/Lower Leg Pain O Abdominal Pain O Dermatitis/Eczema/Rash O Ankle/Foot Pain O Abdominal Pain O Blirth Control Pills O Jaw Pain O Abdominal Pain O Blirth Control Pills O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement O Arthritis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Liver/Gail Bladder Disorder O General Fatigue O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O Pregnancy O Visual Disturbances O Asthria O Dizziness O Chronic Sinusitis O Dizziness O Diabetes O Cancer O Lupus O List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:	Past	Present	Past I	Present	Pas	t Present
O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Angina O Smoking/Use Tobacco Products O Low Back Pain O Angina O Smoking/Use Tobacco Products O Shoulder Pain O Kidney Stones O Drug/Alcohol Dependence O Elbow/Upper Arm Pain O Kidney Disorders O Allergies O Wrist Pain O Bladder Infection O Depression O Hand Pain O Peinful Urination O Systemic Lupus O Hip/Upper Leg Pain O Loss of Bladder Control O Epilepsy O Knee/Lower Leg Pain O Prostate Problems O Dermatitis/Eczema/Rash O Ankle/Foot Pain O Abnormal Weight Gain/Loss O Jaw Pain O Abnormal Weight Gain/Loss O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement O Arthritis O Hepatitis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Hepatitis O Pregnancy O Muscular Incoordination O Tumor O Muscular Incoordination O Tumor O Visual Disturbances O Asthma O Dizziness O Chronic Sinusitis O Dizziness O Diabetes Cancer O Lupus O List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:		O Headaches	0	O High Blood Pressure	0	O Diabetes
O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Smoking/Use Tobacco Products O Low Back Pain O Anglina O Smoking/Use Tobacco Products O Shoulder Pain O Kidney Stones O Drug/Alcohol Dependence O Elbow/Upper Arm Pain O Kidney Disorders O Allergies O Wrist Pain O Bladder Infection O Depression O Hand Pain O Painful Urination O Systemic Lupus O Hip/Upper Leg Pain O Prostate Problems O Dematitis/Eczema/Rash O Ankle/Foot Pain O Abnormal Weight Gain/Loss O Jaw Pain O Abnormal Weight Gain/Loss O Joint Swelling/Stiffness O Ulcer O Hepatitis O Hormonal Replacement O Arthritis O Hepatitis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Hepatitis O Pregnancy O Muscular Incoordination O Tumor O Health Problems/Issues O Dizziness O Chronic Sinusitis O Chronic Sinusitis O Dizziness O Date List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: Date Patient Signature Date			0	O Heart Attack	· · O	O Excessive Thirst
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Doctor/s Additional Comments			***************************************		Dat	fe
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