La Barbera Family Chiropractic, LLC & Re-GEN SoftWave Therapy
2719 Genesee Street, Utica, New York 13501-6556
Phone:(315) 724-0368 Fax:(315) 724-0374

Dr: _____ Date:_____

Case #:_____ Family #:_____

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine the best course of treatment for you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible when completing this form. **PLEASE ANSWER EVERY QUESTION IF POSSIBLE. IF SOMETHING DOES NOT APPLY, WRITE N/A.** Thank You.

PERSONAL INFO:

Patient Name: _____ Nickname: _____
Title First M.I. Last

Sex: _____ Age: _____ Birth Date: _____ SS# _____
Mth-Day-Year

Home Address: _____ Home Phone: _____
No PO's # Street City State Zip

Cell Phone: _____Other Phone: _____ Personal E-Mail: _____

Employer & Address: _____ Work Phone: _____ Ext. _____

Spouse/Partner Name: _____ Cell Phone: _____ Preferred Contact #: _____

Employer & Address: _____ Work Phone: _____Ext. _____

Marital Status: _____ # of children: _____ _____
M-S-W OR D 2 People we can call in case of an emergency & Phone #'s

If Student, School Parent(s) Mother: _____

Name, Address & Grade: _____ Name(s) Father: _____

If Student, Parent Parents (H): _____

Home Address: _____ Phone (W): _____
if different # Street City State Zip Area Code - # ext.

Referred to our office by: _____ Referring Doctor: _____ Primary Doctor: _____

INSURANCE:

Fill out this section with your Health insurance information, No Fault Automobile insurance information or your Worker's Compensation insurance information.

Is this an injury from an accident? ❑Work ❑Auto ❑Home ❑Personal Injury ❑Other Date of Injury: _____

1st Company:_____ ID# _____ Yearly Deductible $ _____ Co-Payment $_____or_____%

Policy Holder: ❑Myself ❑Spouse ❑Father ❑Mother ❑Other Their Birth Date: _____

Patient's Relationship to 1st Policy Holder: ❑Self ❑Spouse ❑Child ❑Other Name: (Policy Holder) _____

2nd Company:_____ ID# _____ Yearly Deductible $ _____ Co-Payment $_____or_____%

Policy Holder: ❑Myself ❑Spouse ❑Father ❑Mother ❑Other Their Birth Date: _____

Patient's Relationship to 1st Policy Holder: ❑Self ❑Spouse ❑Child ❑Other Name: (Policy Holder) _____

Other Insurance Info: _____

_____

Other Personal Info: _____

_____

_____

_____

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HEALTH REPORT

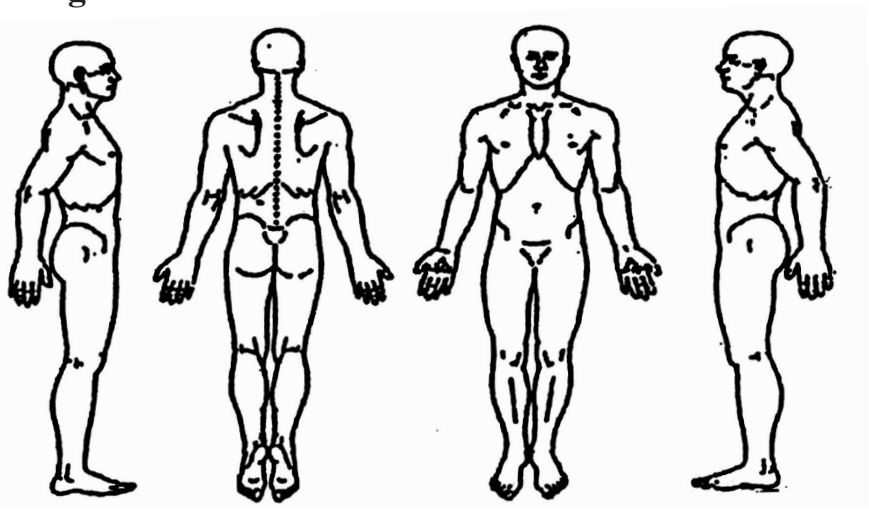
Describe all reasons for seeking treatment here: ❑ Spinal Evaluation ❑ Scoliosis ❑ Poor Posture ❑ Neck Pain ❑ Mid-Back Pain ❑ Low Back Pain
❑ Improved Health ❑ Prevention/Wellness ❑ SoftWave Treatment ❑ Improved Sports Performance ❑ Improved Immune Function ❑ Cranial Care ❑ Other

Describe Your Main Complaints:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Indicate on drawings where you have any pain or symptoms.

Right **Left**



(If you have more than 4 main concerns/problems, please ask the receptionist for an additional sheet)

What is problem/symptom #1? _____
How often do you have symptom #1? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)
How would you describe the type of pain or symptom of #1? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____
How are your symptoms of #1 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better
Using a scale from 0-10 (10 being the worst), how would you rate your symptom #1 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #2? _____
How often do you have symptom #2? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)
How would you describe the type of pain or symptom of #2? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____
How are your symptoms of #2 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better
Using a scale from 0-10 (10 being the worst), how would you rate your symptom #2 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #3? _____
How often do you have symptom #3? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)
How would you describe the type of pain or symptom of #3? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____
How are your symptoms of #3 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better
Using a scale from 0-10 (10 being the worst), how would you rate your symptom #3 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #4? _____
How often do you have symptom #4? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)
How would you describe the type of pain or symptom of #4? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____
How are your symptoms of #4 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better
Using a scale from 0-10 (10 being the worst), how would you rate your symptom #4 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

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Describe in detail HOW your main problem started: _____

_____

_____

DATE your main problem started/1st symptoms:_____ Date of similar condition: _____

Did it start: ❑ Suddenly ❑ Gradually Is it: ❑ Constant ❑ On & Off - % of time _____ Can You Sleep?: ❑ yes ❑ no ❑ On & Off - % of time _____

List any other symptoms that started about the same time (constipation, nausea, dizzy spells, headaches):_____

_____

Changes in ❑ Bladder ❑ Bowel ❑ Sexual function? What?: _____

How much has the main problem(s) interfered with your work? ❑ Not At All ❑ A Little Bit ❑ Moderately ❑ Quite a Bit ❑ Extremely

How much has the main problem(s) interfered with your social activities? ❑ Not At All ❑ A Little Bit ❑ Moderately ❑ Quite a Bit ❑ Extremely

Who else have you seen for your main problem(s)? ❑ Chiropractor ❑ Primary Care Physician ❑ Nurse Practitioner ❑ Neurologist ❑ Orthopedist

❑ Neurosurgeon ❑ ER Physician ❑ Massage Therapist ❑ Physical Therapist ❑ No One ❑ Other: _____

Did it help? ❑ Well ❑ Some ❑ Not at all What did you try at home? (Drugs, Ice, Heat) _____

Do you consider this main problem to be severe? ❑ Yes ❑ Yes, at times ❑ No

What worsens your main problem? _____

What relieves your main problem? _____

What concerns you most about your problem; what does it prevent you from doing? ❑ It is getting worse ❑ It is not going away ❑ It could be something serious

❑ It interferes with my work ❑ It interferes with my recreation/sports ❑ It interferes with my relationship/family ❑ Other: _____

Your: Height _____ Weight _____ Race _____ Nationality _____ Handed: ❑ Left ❑ Right ❑ Both

Recent X-Rays, MRI's, CAT Scans within the last three months: _____

ALL prescription medications now taking: _____

ALL over the counter medications now taking: _____

List all surgeries: ❑ Tonsils ❑ Adenoids ❑ Hysterectomy ❑ Appendix ❑ Gallbladder ❑ Hernia ❑ Back ❑ Neck ❑ Heart ❑ Carpal Tunnel ❑ Eye

Other Surgeries/Procedures: _____

Have you ever been hospitalized? ❑ Yes ❑ No If Yes, when/why: _____

_____

List all broken bones: _____

List all serious accidents: (car, falls, sports etc.)_____

_____

Place a check in the "past" column if you have had the condition in the past. If you presently have a condition, place a check in the "present" column.

Past	Present			Past	Present			Past	Present			Past	Present		
❑	❑	Headaches		❑	❑	Hip Pain	❑L ❑R	❑	❑	Night Time Urination		❑	❑	Dermatitis/Eczema/Rash	
❑	❑	Migraine		❑	❑	Upper Leg Pain	❑L ❑R	❑	❑	Prostate Problems		❑	❑	HIV/AIDS	
❑	❑	Ringing in Ears	❑L ❑R	❑	❑	Knee Pain	❑L ❑R	❑	❑	Impotence (ED)		❑	❑	STD	
❑	❑	Ear Infections	❑L ❑R	❑	❑	Ankle/Foot Pain	❑L ❑R	❑	❑	Neuropathy		❑	❑	Hot Flashes	
❑	❑	Sinus Problems		❑	❑	Numbness Leg/Foot/Toes		❑	❑	Abnormal Weight Gain/Loss		❑	❑	Fibromyalgia	
❑	❑	Visual Disturbances		❑	❑	Cold Hands/Feet		❑	❑	Loss of Appetite		❑	❑	Other: _____	
❑	❑	Dizziness		❑	❑	Jaw Pain/TMJ Problems		❑	❑	Abdominal Pain		❑	❑	Other: _____	
❑	❑	Light Headed		❑	❑	Joint Pain/Stiffness		❑	❑	Reflux GERD		❑	❑	Other: _____	
❑	❑	Seizures		❑	❑	Arthritis		❑	❑	Hiatal Hernia		❑	❑	Other: _____	
❑	❑	Neck Pain		❑	❑	Tumor		❑	❑	Diarrhea		❑	❑	Other: _____	
❑	❑	Grinding Sounds (Neck)		❑	❑	Asthma		❑	❑	Constipation		❑	❑	Other: _____	
❑	❑	Upper Back Pain		❑	❑	Chronic Sinusitis		❑	❑	Hemorrhoids					
❑	❑	Mid Back Pain		❑	❑	Heart Attack		❑	❑	Ulcer					
❑	❑	Low Back Pain		❑	❑	Chest Pains		❑	❑	Hepatitis					
❑	❑	Sciatica	❑L ❑R	❑	❑	Angina		❑	❑	Liver/Gall Bladder Disorder					
❑	❑	Shoulder Pain	❑L ❑R	❑	❑	Kidney Stones		❑	❑	General Fatigue					
❑	❑	Elbow/Upper Arm Pain		❑	❑	Kidney Disorders		❑	❑	Muscular Incoordination					
❑	❑	Numbness Arms/Hands/Fingers		❑	❑	Bladder Infection		❑	❑	Excessive Thirst					
❑	❑	Wrist Pain	❑L ❑R	❑	❑	Painful Urination		❑	❑	Drug/Alcohol Dependance					
❑	❑	Hand Pain	❑L ❑R	❑	❑	Loss of Bladder Control		❑	❑	Allergies					
❑	❑	Weak Grip Strength		❑	❑	Bed Wetting		❑	❑	Depression					
❑	❑	Carpel Tunnel	❑L ❑R	❑	❑	Frequent Urination		❑	❑	Epilepsy					

For Females Only:

❑ ❑ Birth Control Pills
❑ ❑ Hormonal Replacement
❑ ❑ Pregnancy # _____
❑ ❑ Menstrual Pain
❑ ❑ Difficult Pregnancies
❑ ❑ Infertility
❑ Menopause

Date of last period _____

Are you pregnant? ❑ Y ❑ N

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List health problems of spouse & children: _____

_____

Indicate if you currently have or have had any of these conditions:

❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ High Cholesterol/Arteriosclerosis ❑ Fainting ❑ Black Outs ❑ Dizzy Spells ❑ Strokes/TIS's

❑ Neck Arthritis ❑ Whiplash/neck injury ❑ Blood thinners/birth control pills ❑ MS ❑ Cancer ❑ Lupus ❑ ALS ❑ Autoimmune Condition

Indicate if you have any <u>immediate family</u> members who have or have had any of these conditions (grandaparents/parents/siblings):

❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ High Cholesterol ❑ Strokes/TIS's ❑ MS ❑ Cancer ❑ Lupus ❑ ALS ❑ Autoimmune Condition

Previous Chiropractic Care? ❑ yes ❑ no If yes: ❑ Neck problem ❑ Low Back Problem ❑ Prevention ❑ Wellness ❑ Boost Immunity ❑ Enhance sports performance

❑ Last resort for health condition - What condition?:_____ Other reason: _____

What kind of results did you get? ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Overall a bad experience

Your current occupation/job title: _____

What activities do you do at work?

❑ Sit:	❑ Most of the day	❑ Half of the day	❑ A little of the day	❑ Walking:	❑ Most of the day	❑ Half of the day	❑ A little of the day
❑ Stand:	❑ Most of the day	❑ Half of the day	❑ A little of the day	❑ Heavy Labor:	❑ Most of the day	❑ Half of the day	❑ A little of the day
❑ Computer work:	❑ Most of the day	❑ Half of the day	❑ A little of the day	❑ Lifting:	❑ Most of the day	❑ Half of the day	❑ A little of the day
❑ On the phone:	❑ Most of the day	❑ Half of the day	❑ A little of the day	❑ Repetitive Motion:	❑ Most of the day	❑ Half of the day	❑ A little of the day
❑ Drive / Travel:	❑ Most of the day	❑ Half of the day	❑ A little of the day	❑ Other: _____	❑ Most of the day	❑ Half of the day	❑ A little of the day

What activities do you do outside of work? (Sports/Yard Work) _____

What type of exercise do you do? ❑ Strenuous ❑ Moderate ❑ Light ❑ None ❑ Swim ❑ Lift ❑ Run ❑ Golf ❑ Other_____

How would you rate your overall health? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Do you smoke? ❑ No ❑ Never ❑ Yes _____ packs a day ❑ Cigarettes ❑ Cigars ❑ Pipes ❑ Chewing ❑ I quit _____ ago

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach ❑ Cervical Pillow ❑ Waterbed ❑ Firm mattress ❑ Air Mattress ❑ Foam Mattress

❑ Food Allergies: _____ Latex Allergy? ❑ Y ❑ N

Anything else pertinent to your visit today? _____

_____

_____

_____

_____

I authorize the performance upon myself, minor child or person I am guardian for any diagnostic and therapeutic procedures, including necessary X-Rays, Chiropractic Methods or SoftWave Therapy, by legally licensed associates of La Barbera Family Chiropractic LLC and Re-GEN SoftWave Therapy, which they consider advisable in the course of my health care. I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given. I have read the above and understand it and agree that all information I provided is true and complete to the best of my knowledge.

Signed _____ **Date** _____

Patient / Parent / Guardian

DYNAMOMETER L__ R__

Lt _____ Rt _____

Lt _____ Rt _____

Lt _____ Rt _____

LEG LENGTH

Prone _____ Supine _____

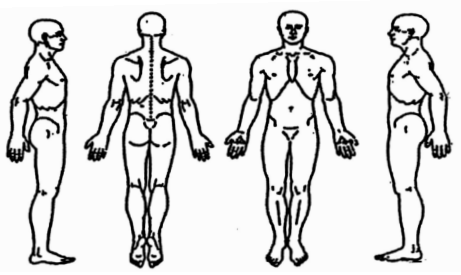
Actual Length

Lt _____ Rt _____

HT _____

WT_____

L / R /



Pulse: _____bpm ❑ Reg ❑ Ir ❑ St ❑ Sh ❑ Ab ❑ S&P ❑ Hd

Resp: _____bpm ❑ Reg ❑ Ir ❑ Sh ❑ Dp ❑ Lb

LOC _____

_____

_____

_____

What is problem/symptom #5? _____

How often do you have symptom #5? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)

How would you describe the type of pain or symptom of #5? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____

How are your symptoms of #5 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your symptom #5 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #6? _____

How often do you have symptom #6? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)

How would you describe the type of pain or symptom of #6? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____

How are your symptoms of #6 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your symptom #6 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #7? _____

How often do you have symptom #7? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)

How would you describe the type of pain or symptom of #7? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____

How are your symptoms of #7 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your symptom #7 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #8? _____

How often do you have symptom #8? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)

How would you describe the type of pain or symptom of #8? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____

How are your symptoms of #8 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your symptom #8 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #9? _____

How often do you have symptom #9? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)

How would you describe the type of pain or symptom of #9? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____

How are your symptoms of #9 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your symptom #9 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What is problem/symptom #10? _____

How often do you have symptom #10? ❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Intermittently (1-25% of the time)

How would you describe the type of pain or symptom of #10? ❑ Sharp ❑ Numb ❑ Dull ❑ Tingly ❑ Diffuse ❑ Sharp with motion ❑ Achy
❑ Shooting with motion ❑ Burning ❑ Stabbing with motion ❑ Shooting ❑ Electric like with motion ❑ Stiff ❑ Other: _____

How are your symptoms of #10 changing with time? ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your symptom #10 intensity? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

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Please answer the following questions. If an explanation is needed, feel free to write it in.

CONSTITUTIONAL

Do you have a Fever or feel warm?	Yes	No	_____
Do you have Chills?	Yes	No	_____
Any unexplained Weight Loss?	Yes	No	_____
Any Malaise (Fatigue, tired, run down)?	Yes	No	_____
Any unexplained Weight Gain?	Yes	No	_____

EYES

Any Diplopia (Double Vision)?	Yes	No	_____
Any Eye Pain?	Yes	No	_____
Any Discharge from the Eyes?	Yes	No	_____
Any Vision Changes?	Yes	No	_____

EARS

Any Ear Drainage?	Yes	No	_____
Ear Pain?	Yes	No	_____
Difficulty Hearing?	Yes	No	_____
Hearing Loss?	Yes	No	_____

NOSE

Do you have Nose Bleeds (Epitaxis)?	Yes	No	_____
Do you have Coryza (Runny nose, congestion, inflammation)?	Yes	No	_____
Any Sinus Pain?	Yes	No	_____

THROAT

Do you have a Sore Throat?	Yes	No	_____
Any Voice Changes?	Yes	No	_____
Do you have Dysphagia (Difficulty or discomfort swallowing)?	Yes	No	_____

MOUTH

Any Cavities or Caries?	Yes	No	_____
Any Mouth Pain?	Yes	No	_____
Any Lesions in your mouth (Sores, bumps, raised areas)?	Yes	No	_____

CARDIOVASCULAR

Any Chest Pain?	Yes	No	_____
Any Dyspnea (Shortness of breath with exertion)?	Yes	No	_____
Any Orthopnea (Shortness of breath when lying down flat)?	Yes	No	_____
Any Heart Palpitations (beating in chest or abnormal beating)?	Yes	No	_____

RESPIRATORY

Any Shortness of Breath?	Yes	No	_____
Any Pleuritic Pain (Sharp pain when breathing sharp in chest)?	Yes	No	_____
Any Hemoptysis (coughing up blood)?	Yes	No	_____
Any Cough?	Yes	No	_____

GI – Gastrointestinal

Any Abdominal Pain (Any Belly / Stomach pain)?	Yes	No	_____
Any Nausea (Feeling sick to your stomach)?	Yes	No	_____
Any Vomiting / Throwing Up?	Yes	No	_____

Any Diarrhea?	Yes	No	_____
Any Constipation (Less than 1 BM a day)?	Yes	No	_____
Any GERD (Acid Reflux / Heartburn / Agita)?	Yes	No	_____
Any Rectal Bleeding (When making a Bowel Movement)?	Yes	No	_____

GU – Genitourinary

Any Pain when urinating (Dysuria)?	Yes	No	_____
Any Change in Frequency (Going more / less than usual)?	Yes	No	_____
Any blood in your urine (Hematuria)?	Yes	No	_____
Any CVA Pain (At the angle formed bt ribs and spine)?	Yes	No	_____
Do you wake at night to urinate (Nocturia)? How many times?	Yes	No	_____

SKIN

Any Rashes?	Yes	No	_____
Any Wounds?	Yes	No	_____
Any Bites?	Yes	No	_____

Neuro – Neurological

Any Seizure activity (starring, shaking, mood changes)?	Yes	No	_____
Any Syncope (Fainting, loss of consciousness)?	Yes	No	_____
Any Numbness (loss of feeling)?	Yes	No	_____
Any Tingling (Tingling, crawly feeling, pins & needles, Etc.)?	Yes	No	_____
Any Weakness?	Yes	No	_____
Any Dizziness (Lightheaded-not you spinning or things around u)	Yes	No	_____

Psych – Psychological

Any Depression?	Yes	No	_____
Any change in Appetite?	Yes	No	_____
Any changes in Sleep?	Yes	No	_____
Do you find no pleasure in life (Anhedonia)?	Yes	No	_____
Have you lost your Sex Drive?	Yes	No	_____
Do you have Suicidal Thoughts?	Yes	No	_____
Any Anxiety (distrust / uneasiness / worry)?	Yes	No	_____

ENDOCRINE

Do you have Excessive Hunger (Polyphagia)?	Yes	No	_____
Do you have Excessive Thirst (Polydipsia)?	Yes	No	_____
Do you have Excessive Urination (Polyuria)?	Yes	No	_____
Do you have Dry Skin?	Yes	No	_____
Any unusual changes in Weight?	Yes	No	_____
Do you have Diabetes Mellitus?	Yes	No	_____

HEME / LYMPH – BLOOD & LYMPHATICS

Is your skin pale or unhealthy in appearance (Pallor)?	Yes	No	_____
Do you have Enlarged lymph glands in the throat) (Kernels)?	Yes	No	_____
Do you have any Infections?	Yes	No	_____
Any feeling of being weak / tired / run down (Weakness)?	Yes	No	_____