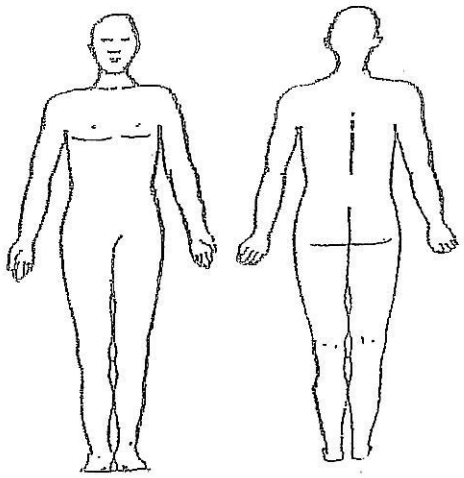
Is this an injury? __Yes __ No Did this occur at work? __Yes __No
Is so, are you filing workman's compensation? __Yes __No
If this is an injury, please state how it occurred. _____

_____

_____

Mark Area of Pain on the
Diagram Below:



Date of onset ____/____/____
Have you had any other treatment for this condition? __Yes __No
Is so, what type? _____
Doctor? _____ Results: ___None ___Fair ___Good
Do you have a hard time falling asleep at night? __Yes __No
Do you awaken often during the night? __Yes __No
Are you allergic to pollen? __Yes __No
Do you wear any inserts in your shoes or built up shoes? __Yes __No

System Review

Please check those symptoms or conditions you have or have had in the last several years.

GENERAL

__Irritability __Crave Sweets __Abnormal hair loss or growth
__Depression __Frequent sinus trouble __Fatigue

HEAD

__Headache __Fainting __Dizziness
__Migraine __Loss of smell __Pain in ears
__Tension __Epileptic seizures __Ringing in ears
__Head feels heavy __Frequent ear infections
__Loss of memory __Inner ear trouble

EYES

__Blinded by lights __Light bothers eyes __Floating spots

NECK

__Pain in neck __Stiff neck __Grating or popping sounds in neck