CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I understand I have a right to review Petsch Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Notice o f Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Petsch Chiropractic Center.

The Notice of Privacy Practices for Petsch Chiropractic Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Petsch Chiropractic Center's duties with respect to my protected health information.

Petsch Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Petsch Chiropractic Center's website (if applicable).

I have the right to revoke this consent, in writing, except to the extent that Petsch Chiropractic Center has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from Dr. Philip Petsch and/or Dr. Rhonda Petsch for my present condition or the patient named below that I am legally responsible for, and for any future condition(s) for which I/we seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date:

Dear Medicare Patient,

We welcome you to our office! Since Medicare coverage is often different from most other insurance companies, we want to inform you of what you can noramally expect from your Medicare Insurance of chiropractic service.

We provide many services for our patients, however, the only service that Medicare Insurance reimburses the patient for is chiropractic manipulation. If you have a secondary insurance coverage it may pick up some of the expenses that Medicare does not. This varies with each company.

Each treatment you receive in our office will consist of at least chiropractic manipulation and manual muscle testing. Medicare should reimburse the chiropractic manipulation but does not cover manual muscle testing. In addition Medicare will not cover examination, vitamins, orthopedic supports, laboratory testing, or any service other than Chiropractic manipulation.

All services given in this office not covered or reimbursed by Medicare are your responsibility. There by signing below you understand that you are responsible for payment of all services not reimbursed and covered by Medicare.

Patient's Signature _____ Date _____

Medicaid Patients:

This office does not accept Medicaid, therefore all charges are your responsibility.

Patient's Signature _____ Date _____

CURRENT COMPLAINT HISTORY

PATIENT NAME: _____

What is the **primary problem** you'd like Dr. Petsch to address?_____

_____

_____

When was the onset? _____How often do you experience it? _____

How long do symptoms last? _____

What treatments have you used?_____

_____

List any **secondary problems**:_____

_____

_____

What is your level of **pain today?** Please circle one. (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

What makes your **symptoms better?**

❑ Nothing ❑ Lying down ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Other_____

What makes your **symptoms worse?**

❑ Nothing ❑ Lying down ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Other_____

Are your symptoms:

❑ Decreasing ❑ Increasing

❑ Not Changing ❑ Other_____

Description of pain or symptoms:

❑ Sharp ❑ Shooting

❑ Dull ❑ Burning

❑ Ache ❑ Numb

❑ Weakness ❑ Tingling

❑ Throbbing ❑ Other_____

Does your pain **move** or **radiate**?

❑ Yes ❑ No Where_____

Check the best and worse **times of the day** for your pain:

Worse	Best
❑ First Awake	❑ First Awake
❑ Morning	❑ Morning
❑ Afternoon	❑ Afternoon
❑ Evening	❑ Evening
❑ Nighttime	❑ Nighttime
❑ Other _____	❑ Other _____

_____

Frequency of pain or symptoms:

❑ Constant (76 – 100%)

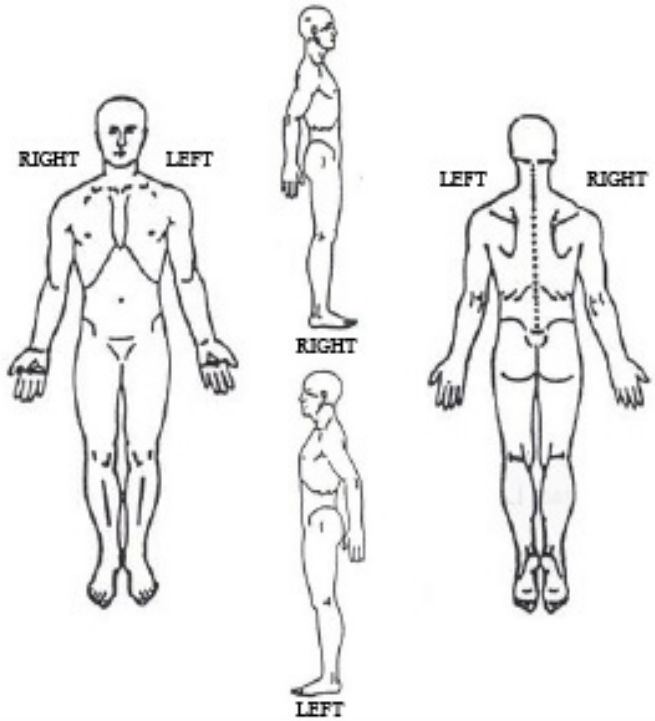
❑ Frequent (51 – 75%)

❑ Occasional (26 – 50%)

❑ Intermittent (25% or less)

SHOW US YOUR PAIN

DRAW ON THE FIGURES WHERE YOU FEEL YOUR SYMPTOMS



How many days out of an **average week** are you in **pain**? (Please circle one) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain**?

❑ Less than 1 hour ❑ 1 to 6 hours ❑ 6 to 12 hours ❑ 12 to 18 hours ❑ 18 to 24 hours ❑ 24 hours

Patient's/Guardian's Signature:_____ Date: _____

Patient Health History Date:_____

Mr. Mrs. Miss Ms. (Please circle one) Last Name: _____ First Name: _____

Birth Date: _____ Age: _____ Marital Status: S M D W

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Email: _____Name of Insured: _____

Medical Insurance Carrier: _____Insured's Date of Birth:_____

Physician's Name: _____ Dentist's Name: _____

Occupation: _____ Employer: _____

How did you hear about us? _____

Past Chiropractic Care: ☐ Yes ☐ No When? _____ Doctor's Name: _____ Results: _____

List any accidents or falls and dates: ☐ Auto: _____ ☐ Recreation: _____

☐ Sports: _____ ☐ Work Related: _____ ☐ Other:_____

List any broken bones (fractures) or dislocation: _____

Were you ever knocked unconscious? ☐ Yes ☐ No (if yes please explain): _____

Have you ever had X-rays taken? ☐ Yes ☐ No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heal lifts? ☐ Yes ☐ No Fitted by whom? _____ When? _____

OPERATIONS AND PROCEDURES

☐ I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other_____

Have you recently experienced any of the following?

____ Death of a loved one
____ Divorce or separation
____ Illness or injury to family or friend
____ Marriage
____ Loss or change of job
____ Retirement
____ Pregnancy or birth of child
____ Sexual problems
____ Change in personal habits
____ Change in living conditions

Please elaborate on above: _____
_____

Does your work/daily activity include any of the following?

____ Exposure to fumes
____ Exposure to chemicals
____ Mental stress
____ Physical stress
____ Sitting ____ Standing for long periods
____ Bending (Frequency: _____)
____ Lifting (Weight: _____)
____ Working overhead

What do you like about your job? _____
_____

Environmental allergies: _____
_____

List your medications/reasons for taking each:

_____
_____
_____
_____
_____

List your vitamin supplements: _____
_____
_____
_____
_____
_____

Rest, Elimination, Diet

Do you sleep on your:

_____ stomach _____ side _____back

Hours of sleep per night: _____

Do you wake up _____ rested _____ tired

Bowel movements per day: _____

Describe BMs: _____

Times you eat out per week: _____

Types of restaurants: _____

Typical breakfast: _____

_____

Typical lunch: _____

_____

Typical dinner _____

_____

Snacks:_____

_____

Food Allergies: _____

_____

Other Allergies: _____

_____

Number of Cigarettes per day: _____

Number of Cups/Glasses/Bottles per day:

Regular Coffee _____ Decaf _____

Regular Tea _____ Herbal Tea _____

Milk _____ (whole/2%/1%/skim)

City Water _____ Filtered Water _____

Well Water _____ Bottled water_____

Regular Pop_____ Sugar Free Pop _____

Juice _____ Energy Drinks _____

Alcohol _____

Exercise

☐ None

☐ Moderate

☐ Daily

Type: _____

_____

Family History

	Diabetes	Heart	Cancer
Mother	☐	☐	☐
Father	☐	☐	☐
Brother(s), # of _____	☐	☐	☐
Sister(s), # of _____	☐	☐	☐

Indicate if you experienced any of the following:

_____ Heart Attack
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Diabetes
_____ Varicose Veins
_____ Hepatitis
_____ TB
_____ Asthma/Emphysema
_____ Chronic Cough
_____ Spinal Curvature
_____ Auto Accident
_____ Blow to Head
_____ Blow to Jaw
_____ Whiplash Injury
_____ Serious Fall
_____ Physical Therapy
_____ Dentures
_____ Bite Adjustments

_____ Orthodontic Treatment
_____ Periodontal Treatment
_____ Teeth Sensitive
_____ Difficulty Chewing
_____ MS
_____ Hypoglycemia
_____ Ulcers
_____ Constipation
_____ Diarrhea
_____ Heartburn or reflux
_____ Poor Digestion
_____ Stomach Gas
_____ Gall Bladder Disorder
_____ Hemorrhoids
_____ Kidney Disorder
_____ Frequent Urination
_____ Urgent Urination
_____ Urinary Dribbling

_____ Cancer
_____ Mononucleosis
_____ Canker Sores
_____ Fatigue
_____ Anemia
_____ Arthritis
_____ Bursitis
_____ Tendinitis
_____ Muscle Cramps
_____ Nervousness
_____ Vertigo
_____ Epilepsy
_____ Difficulty Sleeping
_____ Depression
_____ Psychotherapy
_____ Eye Pain/Pressure
_____ Eye Sensitivity to Light
_____ Sinus Trouble

_____ Headache _____ Location
_____ Migraine Headache
_____ Cold _____ Numb Hands
_____ Cold _____ Numb Feet
_____ Nosebleeds
_____ Swollen Feet or Ankles
_____ Pain _____ Stiff Shoulders
_____ Pain _____ Stiff Neck
_____ Pain _____ Stiff Mid Back
_____ Pain _____ Stiff Low Back
_____ Pain _____ Stiff Legs

Women Only:

_____ Menstrual problems
_____ Cramping
_____ Post-partum Depression
_____ Uterine Ablation
_____ Miscarriage(s)

_____ Excessive Flow
_____ PMS
_____ Menopause
_____ Hot flashes
_____ Number of pregnancies

_____ Clotting or dark flow
_____ Breast tenderness
_____ Hysterectomy
_____ Mood/memory problems
_____ Number of children

I understand and agree that if I have health and/or accident insurance, theses policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider ***will/will*** not prepare reports and forms to assist in reimbursement for the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Patient's/Guardian's Signature: _____ **Date**: _____

HEALTH ASSESSMENT FORM

Name:		
Date of Birth:	**Age:**	**Gender:**
Address:		
City:	**State:**	**Zip:**
Phone:		
Email Address:		
Date:		
Health Care Professional:		

Directions:

Please read each description and darken the box which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, please ask your health care professional to better explain it.

Key:

0 = Never 1 = Mild 2 = Moderate 3 = Severe

Seq	Question	0	1	2	3
Category 1					
1	Bad breath, halitosis	☐	☐	☐	☐
2	Loss of taste for high protein foods	☐	☐	☐	☐
3	Burning ("acid") or nervous stomach, eating relieves	☐	☐	☐	☐
4	Gas shortly after eating	☐	☐	☐	☐
5	Indigestion ½ to 1 hour after eating, may last 3-4 hours	☐	☐	☐	☐
6	Difficulty digesting fruits or vegetables; undigested food found in stools	☐	☐	☐	☐
7	Acid or spicy foods upset stomach	☐	☐	☐	☐
8	Pass large amounts of foul smelling gas	☐	☐	☐	☐
9	Irritable bowel or mucous colitis	☐	☐	☐	☐
10	Dairy products and/or gluten products cause distress	☐	☐	☐	☐
11	Eyes and nose watery	☐	☐	☐	☐
12	Eyes swollen and puffy	☐	☐	☐	☐
13	Pulse speeds after meals and/or heart pounds after retiring	☐	☐	☐	☐
Category 2					
1	Lower bowel gas and/or bloating several hours after eating	☐	☐	☐	☐
2	Feet burn	☐	☐	☐	☐
3	"Whites" of eyes (sclera) yellow	☐	☐	☐	☐
4	Dry skin, itchy feet and/or skin peels on feet	☐	☐	☐	☐
5	Brown spots or bronzing of skin	☐	☐	☐	☐
6	Bitter metallic taste in mouth	☐	☐	☐	☐
7	Blurred Vision	☐	☐	☐	☐
8	Headaches over the eyes	☐	☐	☐	☐
9	Feel nauseous, queasy or gag easily	☐	☐	☐	☐
10	Color of stools light brown or yellow	☐	☐	☐	☐
11	Greasy or high fat foods cause distress	☐	☐	☐	☐
12	Pain between shoulder blades	☐	☐	☐	☐
13	Dark circles under eyes	☐	☐	☐	☐
14	"Acid" breath	☐	☐	☐	☐
15	History of gallbladder attacks or gallstones	☐	☐	☐	☐
16	Gallbladder has been removed	☐	☐	☐	☐
17	Appetite reduced	☐	☐	☐	☐
18	Bowel movements painful or difficult, constipation, and/or laxatives used	☐	☐	☐	☐
19	Constipation, diarrhea alternating or stools alternate from soft to watery	☐	☐	☐	☐
20	Postnasal drip	☐	☐	☐	☐
Category 3					
1	Coated tongue or "fuzzy" debris on tongue	☐	☐	☐	☐
2	Nasal congestion or discharge	☐	☐	☐	☐
3	Restless, figidity	☐	☐	☐	☐
4	Unproductive cough at night or while at rest	☐	☐	☐	☐
5	Urinary urgency or frequency	☐	☐	☐	☐
6	Burning on urination	☐	☐	☐	☐
7	Burning or itching anus	☐	☐	☐	☐
8	Recurrent ear infections or fluid in ears	☐	☐	☐	☐
9	Ear pain or deafness	☐	☐	☐	☐

Seq	Question	0	1	2	3
Category 3 Continued					
10	Fingernail or toenail fungus	☐	☐	☐	☐
11	Skin peeling on bottom of feet and/or hands	☐	☐	☐	☐
Category 4					
1	Head congestion/sinus fullness	☐	☐	☐	☐
2	Sneezing attacks	☐	☐	☐	☐
3	Add the Total Score of Category 1				
4	Add the Total Score of Category 2				
Category 5					
1	Crave sweets and/or coffee in afternoon or mid-morning	☐	☐	☐	☐
2	Hungry between meals or excessive appetite	☐	☐	☐	☐
3	Overeating sweets upsets	☐	☐	☐	☐
4	Eat when nervous	☐	☐	☐	☐
5	Irritable before meals	☐	☐	☐	☐
6	Get "shaky" or light-headed if meals delayed	☐	☐	☐	☐
7	Fatigue, eating relieves	☐	☐	☐	☐
8	Heart palpitates if meals missed or delayed	☐	☐	☐	☐
9	Awaken a few hours after sleep, hard to get back to sleep	☐	☐	☐	☐
Category 6					
1	Muscle soreness after moderate exercise	☐	☐	☐	☐
2	Vulnerability to insect bites (fleas & mosquitoes)	☐	☐	☐	☐
3	Loss of muscle tone or "heaviness" in arms or legs	☐	☐	☐	☐
4	Enlarged heart and/or heart failure	☐	☐	☐	☐
5	Worrier, feel insecure and/or highly emotional	☐	☐	☐	☐
6	Pulse slow/below 65 or irregular pulse	☐	☐	☐	☐
7	Lack of concentration	☐	☐	☐	☐
Category 7					
1	Sex drive increased	☐	☐	☐	☐
2	"Splitting" type headaches	☐	☐	☐	☐
3	Memory failing	☐	☐	☐	☐
4	Tolerance for sugar reduced	☐	☐	☐	☐
Category 8					
1	Sex drive reduced or absent	☐	☐	☐	☐
2	Abnormal thirst	☐	☐	☐	☐
3	Weight gain around hips or waist	☐	☐	☐	☐
4	Tendency to ulcers or colitis	☐	☐	☐	☐
5	Increased ability to eat sugar without symptoms	☐	☐	☐	☐
6	Menstrual disorders (women)	☐	☐	☐	☐
7	Lack of menstruation (young girls)	☐	☐	☐	☐
Category 9					
1	Difficulty gaining weight, even if large appetite	☐	☐	☐	☐
2	Heart palpitations	☐	☐	☐	☐
3	Nervous, emotional and/or can't work under pressure	☐	☐	☐	☐
4	Insomnia	☐	☐	☐	☐
5	Inward trembling	☐	☐	☐	☐

Category 9 Continued								
6	Night sweats	☐	☐	☐	☐			
7	Fast pulse at rest	☐	☐	☐	☐			
8	Intolerant to high temperature	☐	☐	☐	☐			
9	Easily flushed	☐	☐	☐	☐			
Category 10								
1	Difficulty losing weight	☐	☐	☐	☐			
2	Reduced initiative and/or mental sluggishness	☐	☐	☐	☐			
3	Easily fatigued, sleepy during day	☐	☐	☐	☐			
4	Sensitive to cold, poor circulation (cold hands & feet)	☐	☐	☐	☐			
5	Dry or scaly skin	☐	☐	☐	☐			
6	"Ringing" in ears/noises in head	☐	☐	☐	☐			
7	Hearing impaired	☐	☐	☐	☐			
8	Constipation	☐	☐	☐	☐			
9	Excessive hair loss and/or course hair	☐	☐	☐	☐			
10	Headaches when awaken/wear off during day	☐	☐	☐	☐			
Category 11								
1	Blood pressure increased	☐	☐	☐	☐			
2	Headaches	☐	☐	☐	☐			
3	Hot flashes	☐	☐	☐	☐			
4	Hair growth on face or body (Question for Females)	☐	☐	☐	☐			
5	Masculine Tendencies (Question for Females)	☐	☐	☐	☐			
Category 12								
1	Blood pressure decreased	☐	☐	☐	☐			
2	Crave salt	☐	☐	☐	☐			
3	Chronic fatigue/drowsy	☐	☐	☐	☐			
4	Afternoon yawning	☐	☐	☐	☐			
5	Weakness/dizziness	☐	☐	☐	☐			
6	Weakness after colds/slow recovery	☐	☐	☐	☐			
7	Circulation poor	☐	☐	☐	☐			
8	Muscular & nervous exhaustion	☐	☐	☐	☐			
9	Subject to colds, asthma, bronchitis (respiratory disorders)	☐	☐	☐	☐			
10	Allergies and/or hives	☐	☐	☐	☐			
11	Difficulty maintaining manipulative correction	☐	☐	☐	☐			
12	Arthritic tendencies	☐	☐	☐	☐			
13	Nails weak, ridged	☐	☐	☐	☐			
14	Perspire easily	☐	☐	☐	☐			
15	Slow starter in morning	☐	☐	☐	☐			
16	Afternoon headaches	☐	☐	☐	☐			
Category 13								
1	Dreaming, nightmare-like bad dreams	☐	☐	☐	☐			
2	Frequent skin rashes and/or hives	☐	☐	☐	☐			
3	Muscle-leg-toe cramping at rest and/or while sleeping	☐	☐	☐	☐			
4	Fever easily raised/fevers common	☐	☐	☐	☐			
5	Crave chocolate	☐	☐	☐	☐			
6	Feet have bad odor	☐	☐	☐	☐			
7	Hoarseness frequent	☐	☐	☐	☐			
8	Difficulty swallowing	☐	☐	☐	☐			
9	Joint(s) stiff after rising	☐	☐	☐	☐			
10	Vomiting frequent	☐	☐	☐	☐			

Category 13 Continued								
11	Tendency to anemia	☐	☐	☐	☐			
12	Whites" of eyes (sclera) blue	☐	☐	☐	☐			
13	"Lump" in throat	☐	☐	☐	☐			
14	Dry mouth-eyes-nose	☐	☐	☐	☐			
15	White spots on finger nails	☐	☐	☐	☐			
16	Cuts heal slowly and/or scar easily	☐	☐	☐	☐			
17	Reduced or "lost" sense of taste and/or infections	☐	☐	☐	☐			
18	Susceptible to colds, fevers and/or infections	☐	☐	☐	☐			
19	Strong light irritates eyes	☐	☐	☐	☐			
20	Noises in head or ringing in ears	☐	☐	☐	☐			
21	Burning sensations in mouth.	☐	☐	☐	☐			
22	Numbness in hands and feet	☐	☐	☐	☐			
23	Intolerant to monosodium glutamate (MSG)	☐	☐	☐	☐			
24	Cannot recall dreams	☐	☐	☐	☐			
25	Nose bleeds frequent	☐	☐	☐	☐			
26	Bruise easily, "black and blue" spots	☐	☐	☐	☐			
27	Muscle cramps, worse with exercise	☐	☐	☐	☐			
Category 14								
1	Aware of heavy and/or irregular breathing	☐	☐	☐	☐			
2	Discomfort in high altitudes	☐	☐	☐	☐			
3	"Air hunger"/sign frequently	☐	☐	☐	☐			
4	Swollen ankles/worse at night	☐	☐	☐	☐			
5	Shortness of breath with exertion	☐	☐	☐	☐			
6	Dull pain in chest and/or pain radiating into left arm, worse on exertion	☐	☐	☐	☐			
Category 15 (Females)								
1	Premenstrual tension	☐	☐	☐	☐			
2	Painful menses (cramping, etc)	☐	☐	☐	☐			
3	Menstruation excessive or prolonged	☐	☐	☐	☐			
4	Painful/tender breasts	☐	☐	☐	☐			
5	Menstruate too frequently	☐	☐	☐	☐			
6	Acne, worse at menses	☐	☐	☐	☐			
7	Depressed feelings before menstruation	☐	☐	☐	☐			
8	Vaginal discharge	☐	☐	☐	☐			
9	Menses scanty or missed	☐	☐	☐	☐			
10	Still have a menstrual cycle	☐	☐	☐	☐			
11	Hysterectomy/ovaries removed	☐	☐	☐	☐			
12	Menopausal hot flashes	☐	☐	☐	☐			
13	Depression	☐	☐	☐	☐			
Category 16 (Males)								
1	Prostate trouble	☐	☐	☐	☐			
2	Urination difficult or dribbling	☐	☐	☐	☐			
3	Night urination frequent	☐	☐	☐	☐			
4	Pain on inside of legs or heels	☐	☐	☐	☐			
5	Feeling of incomplete bowel evacuation	☐	☐	☐	☐			
6	Leg nervousness at night	☐	☐	☐	☐			
7	Tire easily/avoid activity	☐	☐	☐	☐			
8	Reduced sex drive	☐	☐	☐	☐			
9	Depression	☐	☐	☐	☐			
10	Migrating aches & pains	☐	☐	☐	☐			