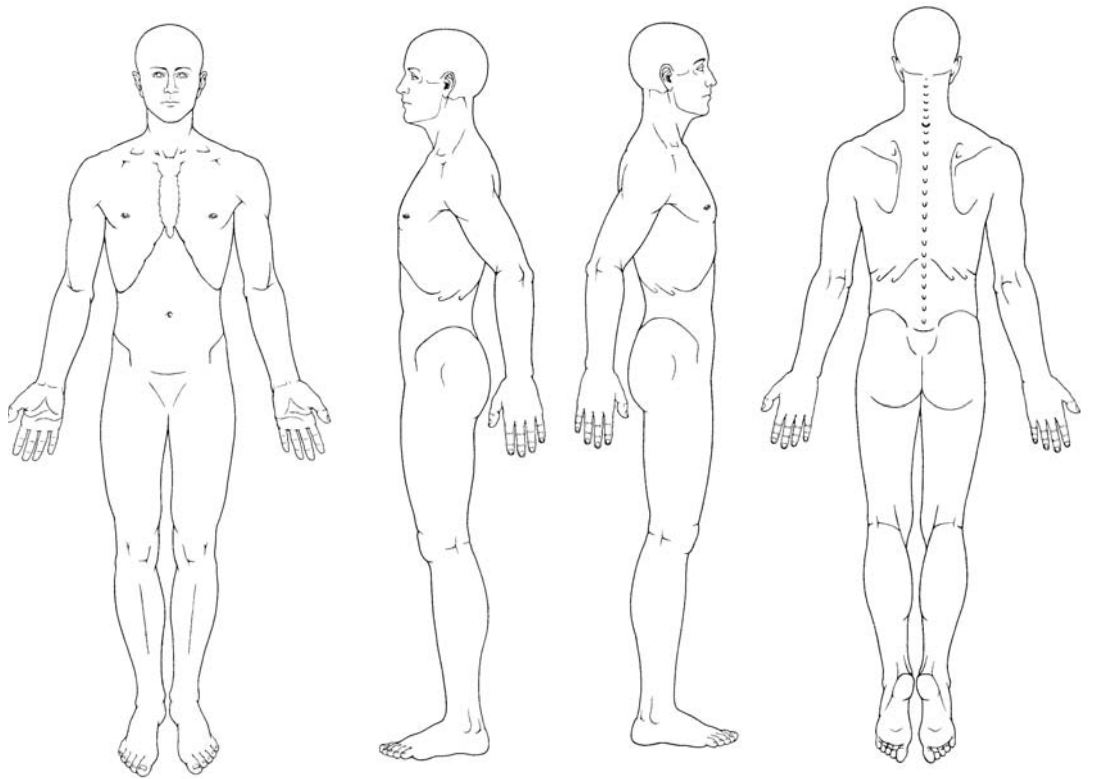


PATIENT SIGNATURE _____

DATE _____

Please mark off the areas of your complaint on the diagram with the following indicators:

- PPP = pain
- NNN = numbness
- TTT = tingling
- BBB = burning
- CCC = cramping
- XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

Please check if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other: Please be sure we know if you have a pacemaker or defibrillator				

PATIENT SIGNATURE _____ DATE _____