

CONFIDENTIAL PATIENT CARE APPLICATION

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WELCOME! Please allow our staff to photocopy your insurance cards and drivers license.
PLEASE PRINT.

Full Name _____ Gender: **M** **F** Home Phone _____

Address _____ Apt. _____ City _____ State _____

Zip _____ Age _____ Birth Date _____ Marital Status (Circle One): **S** **M** **W** **D** **Sep**

No. Children _____ SS# _____

Your Employer _____ Your Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____

Do you have health insurance? Yes No

Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____

Spouse's Employer _____ Spouse's Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____

Does your spouse have health insurance? Yes No

Do you have any other insurance coverage? Yes No What is it? _____

How did you find out about our office? _____

Describe the major complaints that brought you to our office: _____

Is your condition due to an accident? Yes No Date of accident: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release and information deemed appropriate concerning my physical condition to and insurance company, claims adjuster, care nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We file your insurance at no charge to you.

Payment Options (Please Indicate): Cash Check MasterCard Visa Discover

PROBLEM-FOCUSED HISTORY

Name _____ Date _____

CURRENT COMPLAINT:

1. **Where are your symptoms?** _____

How intense is your pain? (no pain 0, low 1-3, moderate 4-6, intense 7-9, emergency 10) If you have more than one area, please list each area and its pain level.

2. **Does your pain spread or radiate?** Y (yes) N (no)

If yes, where to? _____

3. **Onset:** When did it start? _____

How did it start? _____

4. **Type of Sensation:** What does the pain feel like? _____

5. **Frequency (Timing): How often does it occur?**

Intermittent 0-25% (of the time) Occasional 26-50% Frequent 51-75% Constant 76-100%

6. **Does anything make your symptoms worse?** (postures, activities, time of day, etc.) Y N

Explanation: _____

7. **Since they have started, have your symptoms been:**

Decreasing Increasing About The Same Erratic

8. **Change in Bodily Functions:** Y N If yes, Please check those affected.

Balance Bowel Habits Breathing Coordination

Coughing Gait Grip Hearing

Menstrual Sexual Sleep Sneezing

Urination Vision Weakness Weight

9. **Handedness:** L R Ambidextrous

PROBLEM-FOCUSED HISTORY

(CONTINUED)

10. **Change In Activities of Daily Living:** Y N
What do you not do because of this problem? _____

- Forgotten with activity Interferes with activity Activity continues despite problem
 May prevent activity Prevents activity

11. **Work Status: No. of Jobs 1 2 3 (please circle)**

- Full-time Part-time Homemaker Student
 Retired Disabled Unemployed Shift 1 2 3

12. **Work/Home Disability:** Y N

Complete: _____ Days off work
 _____ Days unable to perform household tasks
Partial: _____ Days of job modification
 _____ Days of decreased household tasks

13. **Store-bought or Home Remedies:** Y N

Care not recommended by a doctor.

Type/Effect: _____

14. **Other Professional Care:** Y N

Type, Tests, Diagnosis, Treatment, Results: _____

15. **Does anything help or decrease your symptoms?** Y N

Postures, activities, time of day, etc. Explanation _____

16. **Have you ever had the same or similar condition?** Y N

Explanation: _____

17. **Concurrent Symptoms/Conditions:** Y N

Are you currently under a doctor's care for any other condition(s)? _____

18. **Do You Have A Pacemaker or Any Other Surgically Implanted Device?** Y N

19. **Females: Are You Now or Could You Be Pregnant?** Y N

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

An understanding of your health history helps us to determine appropriate care.

FULL NAME _____ DATE _____ HEIGHT _____ WEIGHT _____

Review of Systems

1. Do you have skin, hair, or nail problems? Yes No _____
2. Do you have mouth and/or throat problems? Yes No _____
3. Do you have nose and/or sinus problems? Yes No _____
4. Do you have ear problems? Yes No _____
5. Do you have eye problems? Yes No _____
6. Do you have chest or lung (breathing) problems? Yes No _____
7. Do you smoke? Yes No Cigarettes per day? _____ How Long? _____
8. Do you have heart and/or blood vessel problems? Yes No _____
9. Do you have blood or lymph node problems? Yes No _____
10. Do you have digestive problems? Yes No _____
11. Do you have genital problems (e.g., prostate, testicular, vaginal)? Yes No _____
12. Do you have urinary (including kidney or bladder) problems? Yes No _____
13. **Females**, have you had menstrual problems? Yes No _____
Have you ever taken birth control pills? Yes No For how long? _____
Is there any chance that you are currently pregnant? Yes No
Do you have any breast problems? Yes No _____
14. Do you have any nervous system diseases and/or mental health problems? Yes No _____
15. Do you have any gland and/or hormone problems? Yes No _____
16. Do you have allergy or immunity problems? Yes No _____
17. Do you have and muscle, tendon or ligament problems? Yes No _____
18. Do you have any bone or joint diseases (examples: bone=osteoporosis, joint=arthritis)? Yes No _____

Past History

19. List any diseases that you have had in the past, including childhood diseases: _____

20. Tell us if you have ever been diagnosed as having a particular condition, such as diabetes, cancer, AIDS, etc.: _____
21. Have you suffered any physical injuries, such as falls or blows, automobile, accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No _____
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

CASE HISTORY

(CONTINUED)

FULL NAME _____ DATE _____

23. Have you ever been hospitalized for any reason other than surgery? Yes No _____

24. **Medication:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____

25. Your diet is: Balanced Fair Poor Excessive Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e., inherited diseases or conditions)? Yes No _____

Social History

27. In what position do you usually sleep, and how well? _____

28. Do you exercise on a regular basis? Yes No How? _____

29. How do you spend your spare time (hobbies, etc)? _____

30. Do you use: Caffeine? Tobacco? Nicotine? Recreational drugs? Alcohol?

31. Please describe your work.
Type: Professional Physical Labor Driver Clerical Factory Homemaker
Physical Demands: Heavy Moderate Mild Sedentary
Stress Level: High Medium Low

Additional Questions

32. Do you have problems with recurring headaches? Yes No

33. Are you losing weight without trying? Yes No

34. Does your pain wake you up at night? Yes No

35. Have you had a change in bowel or bladder habits? Yes No

36. Have you had a sore that doesn't heal? Yes No

37. Have you recently had any unusual bleeding or discharge? Yes No

38. Do you have a thickening/lump in the breast or elsewhere? Yes No

39. Do you have indigestion or difficulty swallowing? Yes No

40. Have you had an obvious change in a wart or mole? Yes No

41. Do you have a nagging cough or hoarseness? Yes No

42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history that was not requested, please fill it in.

44. Who is your:
Medical Doctor? _____
OB/GYN? _____
Dentist? _____

PATIENT HEALTH SURVEY

NAME _____ DATE _____

Have you ever (at any time) experienced any of the following? Please check Y (yes) or N (no)

Difficulty urinating	<input type="checkbox"/> Y	<input type="checkbox"/> N	Claustrophobia (fear of small spaces)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of bladder control	<input type="checkbox"/> Y	<input type="checkbox"/> N	Spinal surgery	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of bowel control	<input type="checkbox"/> Y	<input type="checkbox"/> N	Common cold/flu	<input type="checkbox"/> Y	<input type="checkbox"/> N
Temporary loss of vision, one eye	<input type="checkbox"/> Y	<input type="checkbox"/> N	Carotid artery surgery	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood in urine	<input type="checkbox"/> Y	<input type="checkbox"/> N	Breast removal	<input type="checkbox"/> Y	<input type="checkbox"/> N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatoid arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N	Fractured/broken vertebra	<input type="checkbox"/> Y	<input type="checkbox"/> N
Slipped disc	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bleeding disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N
Herniated disc	<input type="checkbox"/> Y	<input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N
Osteoporosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood in stool	<input type="checkbox"/> Y	<input type="checkbox"/> N
TIA's (pin or mini strokes)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Drop attacks (collapsing, but not fainting)	<input type="checkbox"/> Y	<input type="checkbox"/> N	AIDS	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hardening of the arteries	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Partial or complete paralysis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Prostate disease	<input type="checkbox"/> Y	<input type="checkbox"/> N

Do you currently have, or could you be, any of the following?

Pregnant	<input type="checkbox"/> Y	<input type="checkbox"/> N
Taking birth control pills	<input type="checkbox"/> Y	<input type="checkbox"/> N
Receiving hormone therapy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Male Female		
Receiving chemotherapy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Receiving radiation therapy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Taking blood thinners	<input type="checkbox"/> Y	<input type="checkbox"/> N
A heavy smoker (1 or more packs/day)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Surgical/medical implanted devices:		
Aortic clips	<input type="checkbox"/> Y	<input type="checkbox"/> N
Brain clips	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial heart valves	<input type="checkbox"/> Y	<input type="checkbox"/> N
Rods, pins, screws	<input type="checkbox"/> Y	<input type="checkbox"/> N
IUD	<input type="checkbox"/> Y	<input type="checkbox"/> N
Surgical clips/wires	<input type="checkbox"/> Y	<input type="checkbox"/> N
Shunt	<input type="checkbox"/> Y	<input type="checkbox"/> N
Neurostimulator	<input type="checkbox"/> Y	<input type="checkbox"/> N
Dentures	<input type="checkbox"/> Y	<input type="checkbox"/> N
Pacemaker	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hearing aid	<input type="checkbox"/> Y	<input type="checkbox"/> N
Insulin pump	<input type="checkbox"/> Y	<input type="checkbox"/> N
Joint replacement	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cochlear implants (ear)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other implanted devices:		
Metal fragments(head, eye, skin)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bullets/shrapnel	<input type="checkbox"/> Y	<input type="checkbox"/> N
Body piercing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Tattoos	<input type="checkbox"/> Y	<input type="checkbox"/> N

In the Past 14 days, have you experienced any of the following?

Nausea	<input type="checkbox"/> Y	<input type="checkbox"/> N
Vomiting	<input type="checkbox"/> Y	<input type="checkbox"/> N
Vertigo (spinning)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Difficulty walking	<input type="checkbox"/> Y	<input type="checkbox"/> N
Incoordination	<input type="checkbox"/> Y	<input type="checkbox"/> N
Numbness/sensory complaints	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of consciousness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Double vision	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blurred vision	<input type="checkbox"/> Y	<input type="checkbox"/> N
Tinnitus (ringing in ears)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Speech problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Clumsiness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Memory loss	<input type="checkbox"/> Y	<input type="checkbox"/> N
Long distance travel	<input type="checkbox"/> Y	<input type="checkbox"/> N
Personality changes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Recurrent headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diarrhea	<input type="checkbox"/> Y	<input type="checkbox"/> N
Used a tanning bed/booth	<input type="checkbox"/> Y	<input type="checkbox"/> N
Skin rash/infection	<input type="checkbox"/> Y	<input type="checkbox"/> N
A major fall	<input type="checkbox"/> Y	<input type="checkbox"/> N
A minor fall	<input type="checkbox"/> Y	<input type="checkbox"/> N
An auto accident	<input type="checkbox"/> Y	<input type="checkbox"/> N
A work injury	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of strength	<input type="checkbox"/> Y	<input type="checkbox"/> N
Pain during bowel movements	<input type="checkbox"/> Y	<input type="checkbox"/> N
Head Trauma	<input type="checkbox"/> Y	<input type="checkbox"/> N
Abnormal period	<input type="checkbox"/> Y	<input type="checkbox"/> N

SYSTEM/SYMPTOM REVIEW

NAME _____ DATE _____

Do You Currently Have Any Of The Following? Please check Y (yes) or N (no)

Integument System

Skin rash	<input type="checkbox"/> Y	<input type="checkbox"/> N
Skin lesion	<input type="checkbox"/> Y	<input type="checkbox"/> N
Changes in skin color	<input type="checkbox"/> Y	<input type="checkbox"/> N
Itching (pruritus)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hair changes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Nail Changes	<input type="checkbox"/> Y	<input type="checkbox"/> N

Endocrine System

Hormone problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hot flashes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Thyroid problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hormone therapy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Growth abnormalities	<input type="checkbox"/> Y	<input type="checkbox"/> N
Metabolism Changes	<input type="checkbox"/> Y	<input type="checkbox"/> N

Digestive System

Abdominal pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rectal bleeding	<input type="checkbox"/> Y	<input type="checkbox"/> N
Nausea	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N
Vomiting	<input type="checkbox"/> Y	<input type="checkbox"/> N	Abdominal distention	<input type="checkbox"/> Y	<input type="checkbox"/> N
Constipation	<input type="checkbox"/> Y	<input type="checkbox"/> N	Cramping	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diarrhea	<input type="checkbox"/> Y	<input type="checkbox"/> N	Lump/mass	<input type="checkbox"/> Y	<input type="checkbox"/> N

Cardiovascular System

Chest pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Changes in skin color	<input type="checkbox"/> Y	<input type="checkbox"/> N
Irregular heartbeat	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke (full or pin)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Shortness of breath	<input type="checkbox"/> Y	<input type="checkbox"/> N	Dizziness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Fainting	<input type="checkbox"/> Y	<input type="checkbox"/> N	Cold or cool hands or feet	<input type="checkbox"/> Y	<input type="checkbox"/> N
Fatigue	<input type="checkbox"/> Y	<input type="checkbox"/> N	Varicose veins	<input type="checkbox"/> Y	<input type="checkbox"/> N
Swelling of legs	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral valve problems	<input type="checkbox"/> Y	<input type="checkbox"/> N

Pulmonary System

Coughing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Phlegm/expectorant	<input type="checkbox"/> Y	<input type="checkbox"/> N
Coughing up blood	<input type="checkbox"/> Y	<input type="checkbox"/> N
Shortness of breath	<input type="checkbox"/> Y	<input type="checkbox"/> N
Wheezing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blue skin (cyanosis)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chest pain	<input type="checkbox"/> Y	<input type="checkbox"/> N

Musculoskeletal System

Stiffness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Popping noises	<input type="checkbox"/> Y	<input type="checkbox"/> N
Joint pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weakness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Limitation of movement	<input type="checkbox"/> Y	<input type="checkbox"/> N
Extremity deformities	<input type="checkbox"/> Y	<input type="checkbox"/> N
Difficulty walking	<input type="checkbox"/> Y	<input type="checkbox"/> N

Nervous System

Partial paralysis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Lack of coordination	<input type="checkbox"/> Y	<input type="checkbox"/> N
Complete paralysis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Psychiatric disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N
Headache	<input type="checkbox"/> Y	<input type="checkbox"/> N	Speech abnormalities	<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you right handed?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Visual disturbances	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of consciousness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Are you left handed?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Dizziness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Gait disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N
Memory loss	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y	<input type="checkbox"/> N
Numbness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tics (spasms)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weakness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sensory changes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Depression	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mood changes	<input type="checkbox"/> Y	<input type="checkbox"/> N

SYSTEM/SYMPTOM REVIEW

(CONTINUED)

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NAME _____ DATE _____

Do You Currently Have Any Of The Following? Please check Y (yes) or N (no)

Genital/Urinary System

Pain during urination	<input type="checkbox"/> Y	<input type="checkbox"/> N
Changes in urine flow	<input type="checkbox"/> Y	<input type="checkbox"/> N
Lump or mass in groin	<input type="checkbox"/> Y	<input type="checkbox"/> N
Kidney stones	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chronic bladder infections	<input type="checkbox"/> Y	<input type="checkbox"/> N
Genital itching	<input type="checkbox"/> Y	<input type="checkbox"/> N
Changes in urination frequency	<input type="checkbox"/> Y	<input type="checkbox"/> N
Change in urine color	<input type="checkbox"/> Y	<input type="checkbox"/> N

Special Senses

Visual Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hearing loss	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of balance	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of taste	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of smell	<input type="checkbox"/> Y	<input type="checkbox"/> N
Loss of touch sensation	<input type="checkbox"/> Y	<input type="checkbox"/> N
Temporary vision loss in one eye	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reproductive System

<u>Male Only</u>			<u>Female only</u>		
Testicular pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Abnormal vaginal bleeding	<input type="checkbox"/> Y	<input type="checkbox"/> N
Prostate Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Painful menstruation	<input type="checkbox"/> Y	<input type="checkbox"/> N
Infertility	<input type="checkbox"/> Y	<input type="checkbox"/> N	Breast lump/mass	<input type="checkbox"/> Y	<input type="checkbox"/> N
Impotence	<input type="checkbox"/> Y	<input type="checkbox"/> N	Vaginal discharge/itching	<input type="checkbox"/> Y	<input type="checkbox"/> N
Discharge	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nipple discharge	<input type="checkbox"/> Y	<input type="checkbox"/> N
Lump or mass	<input type="checkbox"/> Y	<input type="checkbox"/> N	Infertility	<input type="checkbox"/> Y	<input type="checkbox"/> N
			Abnormal periods	<input type="checkbox"/> Y	<input type="checkbox"/> N
			Male pattern baldness	<input type="checkbox"/> Y	<input type="checkbox"/> N

Head and Neck Region

Headache	<input type="checkbox"/> Y	<input type="checkbox"/> N	ringing in ears	<input type="checkbox"/> Y	<input type="checkbox"/> N
Neck stiffness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ear pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Neck lump/mass	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ear discharge	<input type="checkbox"/> Y	<input type="checkbox"/> N
Eye pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ear itching	<input type="checkbox"/> Y	<input type="checkbox"/> N
Eye redness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nasal Discharge	<input type="checkbox"/> Y	<input type="checkbox"/> N
Eye discharge	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sinus trouble	<input type="checkbox"/> Y	<input type="checkbox"/> N
Double vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bad breath	<input type="checkbox"/> Y	<input type="checkbox"/> N
Dry eyes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nasal obstruction	<input type="checkbox"/> Y	<input type="checkbox"/> N
Excessive tearing	<input type="checkbox"/> Y	<input type="checkbox"/> N	Snoring	<input type="checkbox"/> Y	<input type="checkbox"/> N
Spinning sensation	<input type="checkbox"/> Y	<input type="checkbox"/> N	Difficulty swallowing	<input type="checkbox"/> Y	<input type="checkbox"/> N

Blood, Lymphatics, Immunology, Allergy

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Frequent illness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Iron deficiency	<input type="checkbox"/> Y	<input type="checkbox"/> N	Immunity problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Clothing problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergies	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bruise easily	<input type="checkbox"/> Y	<input type="checkbox"/> N	Take allergy shots	<input type="checkbox"/> Y	<input type="checkbox"/> N
Swollen lymph nodes	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Doctor's Notes
