EMOTIONAL HEALTH

Have you ever been involved in psychotherapy or counseling? ☐ Yes ☐ No
Duration of time? _____ With whom? _____
Was this work a positive experience? ☐ Yes ☐ No
In what way? _____
If you have previously worked with a counselor, do you feel it would be helpful now?
☐ Yes ☐ No In what way? _____

HOBBIES

List things you enjoy doing. What do you find rewarding about these activities? _____
_____
_____
_____

EXERCISE

Do you exercise? ☐ Yes ☐ No
If Yes, please fill in below

TYPE	FREQUENCY	DURATION	EXERTION LEVEL	BENEFICIAL?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

VOCATION

Do you enjoy your occupation? ☐ Yes ☐ No Does it provide fulfillment? ☐ Yes ☐ No
Describe your work environment _____
Are you content with your current level of income? ☐ Yes ☐ No
Are you exposed to any hazardous materials? ☐ Yes ☐ No
If yes, please list _____
How would you envision a perfect job for yourself? _____

REFERRAL

Referring physician or where you found out about us _____
Referring Physician _____
Phone Number _____

PREVIOUS MEDICAL TREATMENTS

Please list below other practitioners you have worked with in the past (including physicians, chiropractic, acupuncturist, counselors, psychiatrist, energy workers or others)

1. Name _____
   Type of Therapy _____ When Treated _____
   For What _____ Helpful? ☐ Yes ☐ No
2. Name _____
   Type of Therapy _____ When Treated _____
   For What _____ Helpful? ☐ Yes ☐ No
3. Name _____
   Type of Therapy _____ When Treated _____
   For What _____ Helpful? ☐ Yes ☐ No
4. Name _____
   Type of Therapy _____ When Treated _____
   For What _____ Helpful? ☐ Yes ☐ No

Have you had any of the following diagnostic studies?

	Date	Results
☐ Chest X-ray		
☐ Sigmoidoscopy		
☐ Mammogram		
☐ Upper GI		
☐ EKG		
☐ CT or MRI		

PREVIOUS MEDICAL HISTORY

Diagnosis	Problem Started	How Diagnosed	Treatment	Result

OB/GYN

Pregnancies (how many) _____ Any complications? ☐ Yes ☐ No
Explain _____
What was the date of your last pelvic exam/pap test? _____
Was it normal? ☐ Yes ☐ No Do you perform self-breast exam? ☐ Yes ☐ No

HOSPITALIZATIONS AND SURGICAL PROCEDURES

Please list past hospitalizations and any previous medical procedures or surgeries such as tonsillectomy, appendectomy or wisdom tooth extraction etc.

Surgery or Procedure	Date	Reason	Result/Scars

Additional comments on previous medical experience _____

_____

_____

FAMILY MEDICAL HISTORY

	Illness/Condition	Current or Death Age
Grandmother		
Grandfather		
Mother		
Father		
Brothers/Sisters		
Other (relationships)		

TOBACCO/ALCOHOL

Tobacco ☐ Never used ☐ Used from age _____ to _____
☐ Exposed to second-hand smoke
Type used (pipe, cigarettes etc.) _____

Alcohol ☐ Never used ☐ Used from age _____ to _____
Social drinking? ☐ Yes ☐ No How many drinks per week? _____
Any family history of alcoholism? ☐ Yes ☐ No

PREVIOUS MEDICATIONS

Please list medications which you have tried in the past, why you took them and for how long, positive or negative effects, and who prescribed them.

Medicine/Dose	Why	How Long	Effects	Prescribed By

PREVIOUS SUPPLEMENTS

Please list supplements which you have tried in the past, why you took them and for how long, positive or negative effects, and who prescribed them.

Supplements/Dose	Why	How Long	Effects	Prescribed By

SLEEP PATTERNS

Do you have normal, restful sleep?	☐ Yes	☐ No
Do you feel the need to nap?	☐ Yes	☐ No
Do you have trouble getting to sleep?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you wake up frequently?	☐ Yes	☐ No
Are there preparations you have taken to help with sleep?	☐ Yes	☐ No

How often? _____

DIET

What are typical foods you would choose for the following?

Breakfast	Lunch	Dinner	Snacks

How much of the following do you consume each day or week?

	Daily	Weekly
SLICES OF WHITE BREAD, ROLLS OR BAGELS		
CUPS OF CAFFEINATED COFFEE		
CUPS OF CAFFEINATED TEA		
DIET SODAS		
SODA POP CONTAINING CAFFEINE		
SODA POP WITHOUT CAFFEINE		
POTATO CHIPS OR SIMILAR SNACK FOODS		
CANDY		
CHOCOLATE		
CHEESE		
SALTY FOODS		
ICE CREAM		
DOUGHNUTS		

CURRENT MEDICAL TREATMENT

Please list practitioners you consider to be part of your current healthcare team:

1. Name / Phone _____
   Specialty _____
   Condition(s) treated _____
   _____
   Helpful? ☐ Yes ☐ No
2. Name / Phone _____
   Specialty _____
   Condition(s) treated _____
   _____
   Helpful? ☐ Yes ☐ No
3. Name / Phone _____
   Specialty _____
   Condition(s) treated _____
   _____
   Helpful? ☐ Yes ☐ No

CURRENT MEDICATIONS

Please list only the medications you are currently using, why you took them and for how long, positive or negative effects, and who prescribed them.

Medication/Dose	Why	How Long	Effects	Prescribed By

CURRENT SUPPLEMENTS

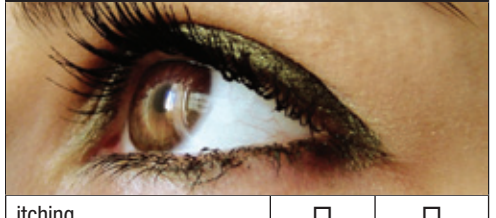
Please list only the supplements you are currently using, why you took them and for how long, positive or negative effects, and who prescribed them.

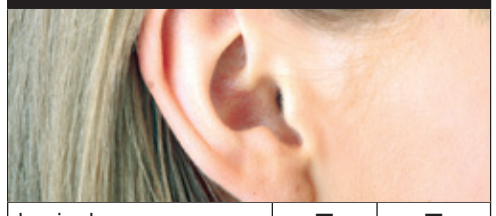
Supplement/Dose	Why	How Long	Effects	Prescribed By

ALLERGIES

Please list any medication, food, or environmental allergy. Use the last page of booklet if additional space is needed.

Allergy	Type of Reaction

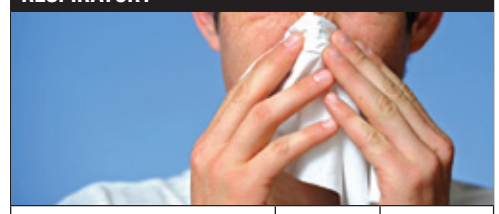
SYMPTOM	PAST	PRESENT
GENERAL		
		
cold hands and feet	☐	☐
cold intolerance	☐	☐
flushing	☐	☐
heat intolerance	☐	☐
fever	☐	☐
fatigue	☐	☐
malaise	☐	☐
difficulty falling asleep	☐	☐
night waking	☐	☐
nightmares	☐	☐
no dream recall	☐	☐
early waking	☐	☐
daytime sleepiness	☐	☐
headache	☐	☐
migraine	☐	☐
	☐	☐
	☐	☐
EYES		
		
itching	☐	☐
blurred vision	☐	☐

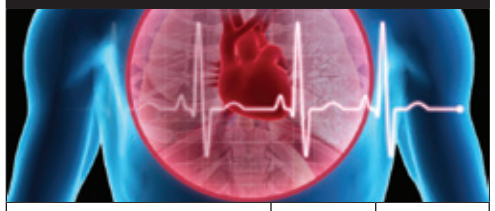
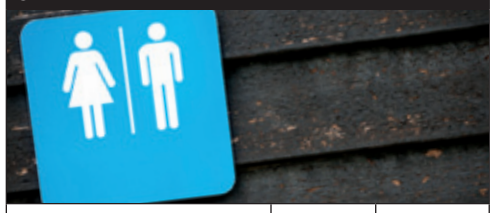
SYMPTOM	PAST	PRESENT
“floaters”	☐	☐
glaucoma	☐	☐
see halos	☐	☐
watering	☐	☐
pain	☐	☐
dark circles	☐	☐
cataracts	☐	☐
double vision	☐	☐
	☐	☐
	☐	☐
EARS		
		
hearing loss	☐	☐
frequent infections	☐	☐
pain	☐	☐
dizziness	☐	☐
ringing	☐	☐
	☐	☐
	☐	☐
EATING		
		
can’t lose weight	☐	☐
can’t gain weight	☐	☐

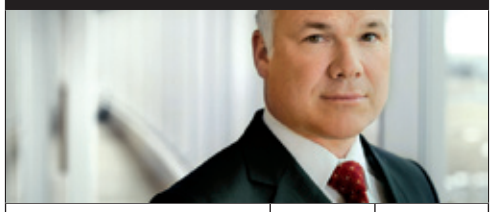
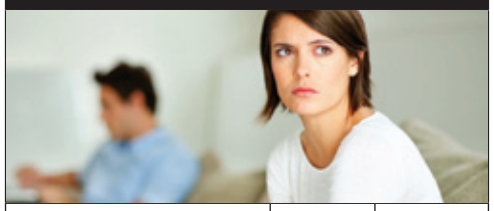
SYMPTOM	PAST	PRESENT
poor appetite	☐	☐
carbohydrate craving	☐	☐
carbohydrate intolerance	☐	☐
binging	☐	☐
bulimia/anorexia	☐	☐
salt craving	☐	☐
alcohol craving	☐	☐
bread craving	☐	☐
chocolate craving	☐	☐
diet soda craving	☐	☐
need coffee	☐	☐
smoke tobacco	☐	☐
used cocaine	☐	☐
used marijuana	☐	☐
used other drugs	☐	☐
	☐	☐
	☐	☐
MUSCULAR		
		
calf cramps	☐	☐
foot cramps	☐	☐
tmj problems	☐	☐
muscle twitches:		
around eyes	☐	☐
arms or legs	☐	☐
muscle spasms	☐	☐
chest tightness	☐	☐
tendonitis	☐	☐
muscle weakness	☐	☐
muscle stiffness	☐	☐
joint swelling	☐	☐
joint pain	☐	☐
joint stiffness	☐	☐
joint redness	☐	☐
	☐	☐
	☐	☐

SYMPTOM	PAST	PRESENT
MOOD/NERVES		
		
anxiety	☐	☐
irritability	☐	☐
depression	☐	☐
panic attacks	☐	☐
agoraphobia	☐	☐
phobias	☐	☐
fearfulness	☐	☐
paranoia	☐	☐
suicidal thoughts	☐	☐
dizzy (spins)	☐	☐
fainting	☐	☐
seizures	☐	☐
difficulty:		
concentrating	☐	☐
with balance	☐	☐
with thinking	☐	☐
with judgment	☐	☐
with speech	☐	☐
with memory	☐	☐
numbness	☐	☐
tingling	☐	☐
	☐	☐
	☐	☐
DIGESTION		
		
upper abdomen pain	☐	☐
lower abdomen pain	☐	☐
bloating of whole abdomen	☐	☐
burping	☐	☐
flatus/gas	☐	☐
diarrhea	☐	☐
undigested food in stools	☐	☐
mucous in stools	☐	☐
blood in stools	☐	☐

SYMPTOM	PAST	PRESENT
hemorrhoids	☐	☐
anal spasms	☐	☐
fissures	☐	☐
strong stool odor	☐	☐
constipation	☐	☐
difficulty swallowing	☐	☐
dentures with poor chewing	☐	☐
bad teeth	☐	☐
gums bleed	☐	☐
periodontal disease	☐	☐
dry mouth	☐	☐
sore tongue	☐	☐
canker sores	☐	☐
fever blisters	☐	☐
cracking at corner of lips	☐	☐
intolerance of lactose	☐	☐
intolerance of all dairy	☐	☐
intolerance of gluten-wheat	☐	☐
intolerance of fatty foods	☐	☐
intolerance of corn	☐	☐
intolerance of yeast	☐	☐
intolerance of eggs	☐	☐
heartburn	☐	☐
nausea	☐	☐
vomiting	☐	☐
	☐	☐
	☐	☐
SKIN		
		
psoriasis	☐	☐
eczema	☐	☐
hives	☐	☐
rash	☐	☐
athletes foot	☐	☐
jock itch	☐	☐
acne	☐	☐
easy bruising	☐	☐
dark circles under eyes	☐	☐
itching	☐	☐
thick callouses	☐	☐

SYMPTOM	PAST	PRESENT
oily skin	☐	☐
dandruff	☐	☐
dry skin	☐	☐
ears get red	☐	☐
strong body odor	☐	☐
herpes - genital	☐	☐
shingles	☐	☐
skin cancer	☐	☐
vitilego	☐	☐
NAILS		
		
soft	☐	☐
brittle	☐	☐
white spots	☐	☐
fungus on fingers	☐	☐
fungus on toes	☐	☐
RESPIRATORY		
		
loss sense of smell	☐	☐
loss sense of taste	☐	☐
nasal stuffiness	☐	☐
sinus fullness	☐	☐
sinus infection	☐	☐
post nasal drip	☐	☐
bad odor in nose	☐	☐
bad breath	☐	☐
nose bleeds	☐	☐
hay fever - spring	☐	☐
hay fever - summer	☐	☐
hay fever - fall	☐	☐
hay fever - seasonal	☐	☐
winter stuffiness	☐	☐
sore throat	☐	☐
hoarseness	☐	☐
shortness of breath	☐	☐
cough - dry	☐	☐

SYMPTOM	PAST	PRESENT
cough - productive	☐	☐
wheezing	☐	☐
odor sensitive	☐	☐
	☐	☐
	☐	☐
CARDIOVASCULAR		
		
high blood pressure	☐	☐
palpitations	☐	☐
heart pounding	☐	☐
rapid pulse	☐	☐
irregular pulse	☐	☐
chest pain	☐	☐
heart attack	☐	☐
mitral valve prolapse	☐	☐
heart murmur	☐	☐
varicose veins	☐	☐
phlebitis	☐	☐
spider veins	☐	☐
ankle swelling	☐	☐
	☐	☐
	☐	☐
URINARY		
		
urgency	☐	☐
leaking	☐	☐
pain	☐	☐
hesitancy	☐	☐
kidney stone	☐	☐
infection	☐	☐
bleeding	☐	☐
incontinence	☐	☐
	☐	☐
	☐	☐

SYMPTOM	PAST	PRESENT
MALE		
		
prostate infection	☐	☐
prostate enlargement	☐	☐
infertility	☐	☐
impotence	☐	☐
ejaculation problem	☐	☐
genital pain	☐	☐
poor libido	☐	☐
testicular lumps	☐	☐
	☐	☐
	☐	☐
FEMALE REPRODUCTIVE		
		
vaginal discharge	☐	☐
vaginal odor	☐	☐
vaginal itch	☐	☐
poor libido	☐	☐
breast lumps	☐	☐
breast cysts	☐	☐
premenstrual:		
bloating - face	☐	☐
bloating - abdomen	☐	☐
puffy hands	☐	☐
puffy feet	☐	☐
breast tenderness	☐	☐
irritability	☐	☐
diarrhea	☐	☐
constipation	☐	☐
decreased sleep	☐	☐
chocolate craving	☐	☐
carbohydrate craving	☐	☐
food craving	☐	☐
	☐	☐
	☐	☐

Age at first period _____

Did you ever use birth control pills?
from _____ to_____
from _____ to_____
from _____ to_____

Did taking the pill agree with you? ☐ yes ☐ no

Are you taking the pill now? ☐ yes ☐ no

Contraception use now? ☐ yes ☐ no

Date of last pap smear _____

If you are post menopause, do you take?
☐ estrogen ☐ estrace ☐ premarin
☐ progesterone ☐ provera

Age at last (final) period _____

PREGNANCIES: (INDICATE NUMBER)

Miscarriages _____ Abortions _____

Preemies _____ Term births _____

Toxemia _____

Nausea/vomiting ☐ mild ☐ moderate ☐ severe

Other problems:
_____
_____
_____
_____

ENVIRONMENTAL QUESTIONS

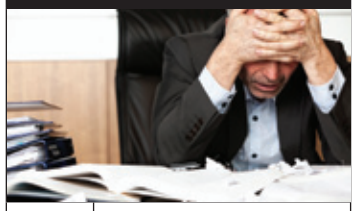
Have you ever or do you use any of the following at/near home or work?

	Home	Work		Home	Work
spring water	☐	☐	foam rubber pillows	☐	☐
well water	☐	☐	feather/down:		
water purifier	☐	☐	comforter	☐	☐
damp cellar	☐	☐	coat/jacket	☐	☐
wooded area	☐	☐	hair dyes	☐	☐
power lines	☐	☐	exterminator	☐	☐
smoke stacks	☐	☐	stuffed upholstery	☐	☐
dump	☐	☐	moth balls	☐	☐
gas stove	☐	☐	animals	☐	☐
gas furnace	☐	☐	mold on:		
gas hot water heater	☐	☐	shower curtain	☐	☐
gas dryer	☐	☐	basement walls	☐	☐
wood stove	☐	☐	first story walls	☐	☐
coal stove	☐	☐	second story walls	☐	☐
kerosene space heater	☐	☐	garage under living space	☐	☐
forced hot air heat	☐	☐	urea formaldehyde insulation	☐	☐
electric blankets	☐	☐	garden chemicals	☐	☐
feather pillows	☐	☐			

ARE YOU BOTHERED BY: (NOTE SYMPTOMS)

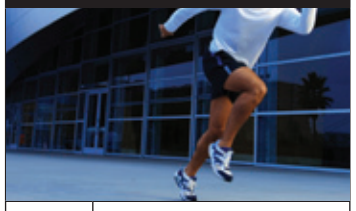
☐ gasoline fumes _____	☐ fabric stores _____
☐ diesel exhaust _____	☐ new car smell _____
☐ soaps _____	☐ air conditioners _____
☐ detergents _____	☐ newsprint _____
☐ chlorinated water _____	☐ tobacco smoke _____
☐ moth balls _____	☐ cats _____
☐ asphalt/tar _____	☐ dogs _____
☐ hair spray _____	☐ mold _____
☐ cosmetics _____	☐ tree pollen _____
☐ perfumes _____	☐ grass pollen _____
☐ dust _____	☐ ragweed pollen _____

ADRENAL FUNCTION



☐	fatigue
☐	exhaustion
☐	low blood pressure
☐	nervousness
☐	irritability
☐	difficulty overcoming infections
☐	anxiety
☐	depression
☐	food sensitivities
☐	hypoglycemia
☐	headaches
☐	poor concentration
☐	minimal body hair
☐	pms symptoms
☐	tendency for prolonged illness
☐	poor stress tolerance (emotional or physical)

THYROID FUNCTION



☐	increase in weight
☐	headaches
☐	difficulty losing weight
☐	fatigue
☐	water retention
☐	low sex drive
☐	slow thinking
☐	always feel cold
☐	cold hand/feet
☐	pms symptoms
☐	constipation
☐	heavy, irregular or missed periods
☐	insomnia
☐	hypoglycemia
☐	diminished capacity to sweat
☐	dry skin
☐	diabetes
☐	high cholesterol
☐	brittle nails

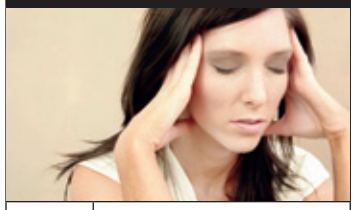
DIGESTION AND ABSORPTION

☐	gas
☐	bloating
☐	fullness
☐	nausea
☐	constipation
☐	diarrhea
☐	abdominal cramps
☐	fatigue
☐	hives
☐	food sensitivities
☐	history of traveler's diarrhea
☐	yeast infections
☐	history of antibiotic use

BOWEL FUNCTION

☐	constipation
☐	poor digestion
☐	bowel movements less than once daily
☐	heavy laxative use
☐	bad breath
☐	incomplete elimination
☐	excessive gas
☐	body odor
☐	coated tongue
☐	acne
☐	fatigue
☐	headaches
☐	food sensitivities
☐	ulcers
☐	bloating

HYPOGLYCEMIA



☐	fatigue
☐	irritability
☐	headache
☐	depression
☐	mental confusion
☐	mood swings
☐	weakness
☐	insomnia
☐	hunger
☐	palpitations
☐	light-headedness
☐	excessive sweating

CANDIDA (YEAST) SENSITIVITY

☐	gas
☐	bloating
☐	recurrent bladder infections or irritations
☐	chronic rashes
☐	heartburn
☐	constipation or diarrhea
☐	spastic or irritable colon
☐	joint or muscle pain
☐	infertility
☐	itchy anus
☐	recurrent staph infection
☐	multiple allergies
☐	weight problems
☐	craving for sweets, alcohol or bread
☐	multiple pregnancies
☐	birth control pill
☐	fatigue
☐	depression
☐	recurrent or chronic vaginal yeast infections
☐	general itchiness
☐	antibiotic use
☐	irritability
☐	premenstrual symptoms
☐	intestinal cramping
☐	cortisone or steroid use
☐	inability to concentrate
☐	chemical or fume intolerance
☐	worsening of any of the above

FOOD SENSITIVITIES

☐ feel worse after eating	☐ spastic irritable colon	☐ flu like symptoms that are not the flu	☐ crohn's disease, colitis
☐ depression	☐ indigestion	☐ fatigue	☐ itchy anus
☐ total exhaustion	☐ arthritis	☐ weakness	☐ muscle pains
☐ poor memory	☐ muscular weakness	☐ poor concentration	☐ bed-wetting
☐ brain fogginess, dopiness, confusion	☐ frequent urination	☐ hyperactivity	☐ genital itch
☐ learning disability	☐ painful or irregular menstrual periods	☐ inappropriate rage or emotional outbursts	☐ hives, rashes, acne
☐ headaches	☐ dark circles under eyes	☐ insomnia	☐ asthma
☐ delusions	☐ coughing	☐ chronic sore throat	☐ high blood pressure/ low blood pressure
☐ mucous in throat, nose or sinuses	☐ palpitations	☐ recurrent ear, sinus or other respiratory infection	☐ phlebitis
☐ canker or cold sores	☐ weight problems	☐ bloating or gas	☐ irritated eyes

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing