SOUTH FLORIDA INJURY CENTERS
1700 SE Hillmoor Drive, Suite 502
Port Saint Lucie, FL 34952
Ofc# (772) 333-2648 Fax# (772) 621-5131

GENERAL RELEASE & RELEASE OF MEDICAL RECORDS

TO ALL CONCERNED REGARDING THIS MATTER: That I have requested the release of the X-rays and medical records of:

_____,
Print Patient's Name

Patient's DOB: _____ Patient's SS#_____

I hereby acknowledge receipt of their X-ray films and medical records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid Doctor of Chiropractic from any and all responsibility or liability of any kind, nature, or character whatsoever arising from said treatment.

_____
Patient or legal representative's signature

_____
Date

South Florida Injury Centers, Inc.
1700 SE Hillmoor Drive, Suite 502
Port St. Lucie, FL 34952

Date**: ___/_____/_____**

PLEASE PRINT AND WRITE N/A IF ANYTHING DOES NOT APPLY.

Name: _____ Age: _____ Date of Birth: ___/___/_____ ❑Male ❑Female

Address: _____City: _____State: _____Zip Code:_____

Cell # (_____) _____ Email:_____

Occupation: _____Marital Status: ❑ Married ❑ Single ❑Widowed

Social Security #:_____-_____-_____ Emergency Contact:_____

Phone #: (___) _____

PRESENT COMPLAINT

Describe your problem: _____

_____

Have you been treated for this condition? ❑YES ❑NO

(If YES, give DOCTOR'S NAME):_____

Were you taken to the hospital? ❑YES ❑NO

(If YES, provide NAME OF HOSPITAL and SERVICES PROVIDED):_____

_____

Have you missed any work? ❑YES ❑NO (If YES, provide DATES): _____

MEDICAL HISTORY

❑ POLIO	❑ DIABETES	❑ RHEUMATISM	❑ MULTIPLE SCLEROSIS
❑ ANEMIA	❑HEPATITIS	❑ CONCUSSION	❑ DIGESTIVE DISORDER
❑ ASTHMA	❑ ARTHRITIS	❑ CONVULSIONS	❑ NEURITIS
❑ CANCER	❑ DIZZINESS	❑ NERVOUSNESS	❑ EPILEPSY
❑ BACKACHES	❑ NUMBNESS	❑ SINUS TROUBLE	❑ HEART TROUBLE

❑ HIGH BLOOD PRESSURE ❑ OTHER: _____

Have you had any surgeries? ❑YES ❑NO (If YES, list dates of SURGERY):_____

_____

Do you drink alcohol? ❑ YES ❑NO
Do you smoke cigarettes? ❑YES ❑NO
Do you exercise? ❑YES ❑NO (If YES, describe):_____

Do you have a family history of heart disease, diabetes or cancer? ❑ YES ❑NO

If so, who? : _____

Have you had any prior Motor Vehicle Accidents? ❑YES ❑NO If yes, when? _____

Please describe injuries and treatment for the prior accident (including surgeries, injections etc…):_____

Have you had any prior illnesses/injury not related to an auto accident? ❑YES ❑NO

Please describe: _____

Were you treated by a physician for any condition in the last 12 months? ❑YES ❑NO

(If YES, describe condition):_____

_____

Date of last physical exam: ___/___/_____ Date of last menstrual period: ___/___/_____

Are you pregnant? ❑YES ❑NO

Name of Physician_____Phone #: _____

Allergic to any medication? ❑ YES ❑NO (If YES, what medications?): _____

_____

Taking any medications? ❑YES ❑NO (If YES, what medications?): _____

_____

❑ AUTO ACCIDENT- PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Date of Accident: ___/___/_____

Did you report the accident to your Auto company? ❑ YES ❑ NO
(IF YES, What is the Claim # for your Auto company):_____

What kinds of vehicles were involved? ❑Truck ❑Car ❑SUV ❑Motorcycle ❑Bus ❑Tractor Trailer

❑Bicycle ❑OTHER _____

Were you a: ❑Driver ❑ Passenger (front) ❑ Back Passenger (L) (M) (R) ❑ Pedestrian

Was your vehicle moving when the accident occurred? ❑YES ❑NO

Did your vehicle hit other vehicles? ❑YES ❑NO Where? _____

Did the other vehicle hit your vehicle? ❑YES ❑NO Where?

_____

Were airbags deployed? ❑YES ❑NO

Did you lose consciousness? ❑YES ❑NO

Did EMS (Emergency Medical Services) arrive at the scene? ❑YES ❑NO

Where you transported to the hospital by EMS? ❑YES ❑NO

If YES, what facility you transported to? _____

_____

Describe the accident including causes and surrounding/circumstances (weather, visibility, speed, traffic pattern): _____

_____

_____

_____

_____

I _____attest that the above report is the truth to the best of my knowledge.

Signature: _____Date___/____/_____

SOUTH FLORIDA INJURY CENTERS, INC.
CONSENT TO MEDICAL CARE

1700 Hillmoor Drive, Suite 502
Port Saint Lucie, FL 34952

PLEASE READ THIS FORM CAREFULLY & COMPLETELY BEFORE SIGNING

I, _____, understand that I have a condition that requires medical treatment. I authorize the Doctor(s) of SOUTH FLORIDA INJURY CENTERS, INC. to determine what kinds of diagnostic procedures (tests) must be dome in order to learn more about my condition. These may include x-rays, pathological testing, diagnostic testing, or other testing. I understand that if my doctor advises a more complex test, or one, which has special risks, that it will be explained to me. Further, I authorize the personnel of SOUTH FLORIDA INJURY CENTERS, INC. to assist in giving, or to give, the tests, which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health.

Additionally, I authorize the personnel of SOUTH FLORIDA INJURY CENTERS, INC. to assist in the giving, or to give, the therapy, which my doctor may order. I fully understand that medical tests or treatments may involve certain unavoidable risks, if part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment, which I might receive. However, I acknowledge that my doctor is available to answer any questions I might have.

FOR FEMALES OF CHILD BEARING AGE: I certify that to my knowledge I am not, or could be, pregnant and failure to disclose this condition could result in harm to my unborn child if exposed to radiation through x-ray. Therefore, I consent to any diagnostic x-rays that my doctor would need to diagnose my condition and enable him/her to render treatment.

I certify that I have read this form and have had it explained to me. I further certify that I fully understand its contents.

_____ _____

Signature Date

_____

Witness

FOR PATIENTS UNABLE TO SIGN OR MINORS

_____ _____ _____

Legal Representative Relationship Date

INFORMED CONSENT DOCUMENT

PATIENT NAME:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:(please initial each)

___Spinal Manipulative therapy
___Range of motion testing
___ Muscle strength testing
___Ultrasound
___ Radiographic studies
___Other(please explain)

___Palpation
___ Orthopedic testing
___ Postural Analysis
___Hot/Cold therapy
___ Vital signs
___ Basic neurological testing

___ EMS
___ Shockwave
___ Therapeutic Exercises

_____

_____

The material risks inherent in chiropractic adjustment.

As with healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

INFORMED CONSENT DOCUMENT

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti- inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW

I have read ( ) or have had read to me ( ) the explanation of the chiropractic adjustment and related treatment. I have had discussed it with South Florida Injury Centers Doctor and have had my questions answered to my satisfaction. By signing below I state I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having informed of the risks, I hereby give my consent to that treatment.

Date: _____ **Date:** _____

_____ _____

Patient's Printed Name **Doctor's Name**

_____ _____

Patient's Signature **Doctor's Signature**

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, and public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to you records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting Office Manager.

Name_____ Phone_____

The effective date of this Notice of Information Practices is April 14, 2004.

Thank you.

SOUTH FLORIDA INJURY CENTERS, Inc.
1700 SE Hillmoor Drive, Suite 502
Port Saint Lucie, FL 34952

AUTHORIZATION OF SIGNATURE

I _____ hereby authorize Dr. Brian S. Wilner to affix my signature for endorsement of checks made payable to me and Dr. Brian S. Wilner for Chiropractic payment.

___/____/_____
Date

_____
Patient's Printed Name

_____
Patient's Signature

SOUTH FLORIDA INJURY CENTERS, Inc.
1700 SE Hillmoor Drive, Suite 502
Port Saint Lucie, FL 34952

AUTHORIZATION TO PAY DOCTOR

I hereby authorize _____(insurance company) to pay by check made out and mailed to:

South Florida Injury Centers, Inc.
5715 N. University Dr.
Tamarac, FL 33321

The expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charged over and above this insurance payment.

_____
Date

_____
Patient's Printed Name

_____
Patient's Signature

SOUTH FLORIDA INJURY CENTERS, INC.
1700 SE Hillmoor Drive, Suite 502
Port Saint Lucie, FL 34952

HARDSHIP AGREEMENT

Date: _____

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive care. I am requesting a delay in payment for my treatment based on financial hardship.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

Patient's printed name: _____

Patient's signature: _____

Witness' signature: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our office.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

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

_____ _____

Patient Signature Date

Review of Systems Name: Date: / /

General ☐**NONE**
☐Unexplained Weight Loss ☐Fever ☐Trouble Sleeping ☐Weakness ☐ Unexplained Weight Gain ☐Chills
☐Recent cold or flu ☐Fatigue

Skin ☐**NONE**
☐Rashes ☐Itching ☐Color Changes ☐Lumps ☐Dryness ☐Hair & Nail Changes

Head ☐**NONE**
☐Headache ☐Head injury/Trauma ☐Bumps or areas of tenderness

Eyes ☐**NONE**
☐Visual Problems ☐Blurry Vision ☐Double Vision ☐Wear glasses/Contacts ☐Flashing Lights ☐Specks or spots in vision ☐Pain
☐Glaucoma ☐Itching ☐Redness

Ears ☐**NONE**
☐Decreased Hearing ☐Earache/pain ☐Ringing in ears (tinnitus) ☐Fluid Discharge from ear(s)

Nose ☐**NONE**
☐Stuffiness ☐Itching ☐Nosebleeds ☐Fluid Discharge ☐Hay Fever ☐Sinus Pain

Throat ☐**NONE**
☐Toothache ☐Pain with Swallowing ☐Sore tongue ☐Bleeding Gums ☐Non-healing sores ☐Hoarseness ☐Lump in Throat ☐Dry mouth

Neck ☐**NONE**
☐Lumps ☐Pain ☐Swollen Glands ☐Stiffness

Breasts ☐**NONE**
Do you do self-Exams? ☐YES ☐NO ☐Lumps ☐Discharge Are you breast feeding? ☐YES ☐NO

Respiratory ☐**NONE**
☐Coughing (dry or wet, productive) ☐Coughing up blood ☐Shortness of breath ☐Labored Breathing
☐Sputum/Color_____
☐Painful Breathing ☐Wheezing

Cardiovascular ☐**NONE**
☐Chest pain or discomfort ☐Difficulty breathing when lying down ☐Chest or shoulder/arm pain with activity ☐Tightness in chest
☐Shortness of breath with activity ☐Sudden awakening from sleep w/ shortness of breath ☐Palpitations

Gastrointestinal ☐**NONE**
☐Difficulty Swallowing ☐Change in bowel habits ☐Yellow eyes or skin ☐Nausea ☐Diarrhea ☐Heartburn ☐Rectal Bleeding
☐Gas or bloating ☐Abdominal pain after or during meal ☐Change in appetite ☐Constipation ☐Abdominal pain prior to meal

Urinary ☐**NONE**
☐Urinate frequently ☐Blood in urine ☐Yellow eyes or skin ☐Feel like urinating but can't or little ☐Change in urinary strength
☐Incontinence ☐Burning with urination

MALE **Do you do regular testicular exams? ☐YES ☐NO**
☐**NONE**
☐Sores ☐Pain with Sex ☐STDs, if yes which_____ ☐Erectile Dysfunction ☐Penile Discharge ☐Hernia ☐Masses or pain
FEMALE ☐**NONE**
☐Pain with sex ☐STDs, if yes which _____ ☐Vaginal Discharge ☐Vaginal dryness ☐Hot flashes

Vascular ☐**NONE**
☐Calf pain ☐Leg Cramping

Musculoskeletal ☐**NONE**
☐Muscle or joint pain ☐Back pain ☐Neck pain ☐Stiffness ☐Redness of the joints ☐Trauma ☐Swelling of joints

Neurological ☐**NONE**
☐Dizziness ☐Weakness ☐Tremors ☐Fainting ☐Numbness ☐Headaches ☐Seizures ☐Tingling

Hematologic ☐**NONE**
☐Bruising Easily ☐Bleeding Easily

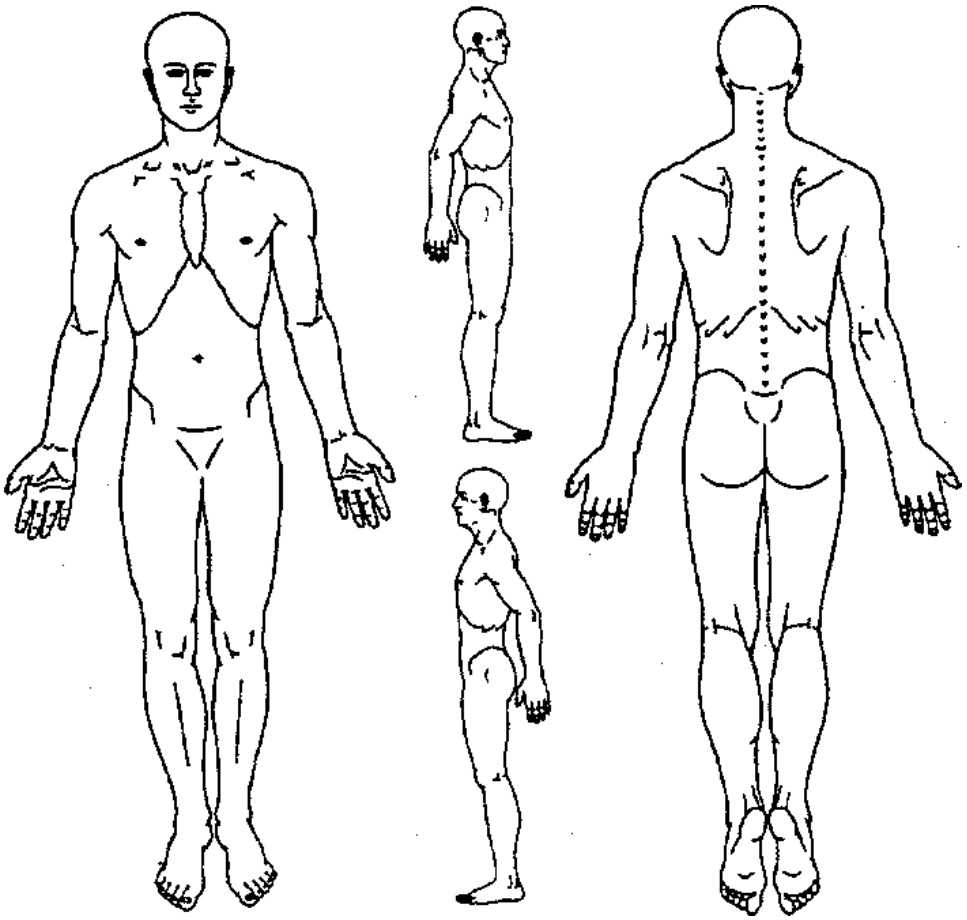
Endocrine ☐**NONE**
☐Heat or Cold intolerance ☐Frequent Urination ☐Change in appetite ☐Sweating ☐Increase Thirst

Psychiatric ☐**NONE**
☐Nervousness ☐Memory Loss ☐Stress ☐Depression ☐Anxiety

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

_____

_____

_____

Date: _____ Signature: _____