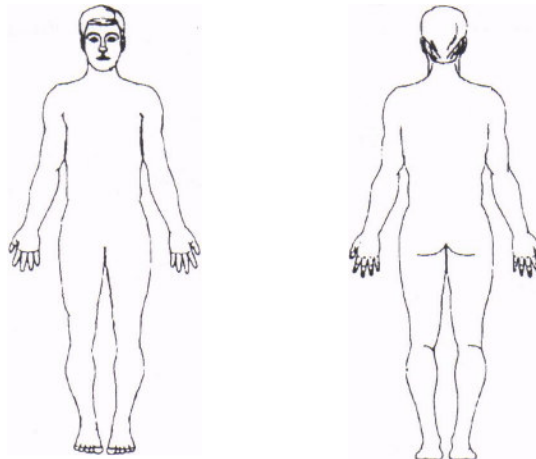


Please shade in the figures below where you have pain or other symptoms:



OVER

PAST OR CURRENT SYMPTOMS/CONDITIONS

| Symptom | Past | Present |
|---------------------------------|------|---------|
| | () | () |
| Neck Pain | () | () |
| Shoulder Pain..... | () | () |
| Arm/elbow Pain..... | () | () |
| Hand Pain..... | () | () |
| Upper Back Pain..... | () | () |
| Lower Back Pain..... | () | () |
| Pain in upper leg or hip | () | () |
| Pain in lower leg or knee | () | () |
| Pain in ankle or foot..... | () | () |
| Jaw Pain..... | () | () |
| Swelling/stiffness of joints .. | () | () |
| Headaches | () | () |
| Dizziness..... | () | () |
| Fainting Spells | () | () |
| Convulsions | () | () |
| General prolonged fatigue.. | () | () |
| Condition of uterus/ovaries | () | () |

| Symptom | Past | Present |
|-------------------------------|------|---------|
| | () | () |
| High Blood Pressure..... | () | () |
| Heart Condition..... | () | () |
| Respiratory condition..... | () | () |
| Digestive problems | () | () |
| Kidney/bladder problem..... | () | () |
| Menstrual problems | () | () |
| Breast soreness/lump | () | () |
| Sinus conditions..... | () | () |
| Allergies/asthma..... | () | () |
| Cancer | () | () |
| Stroke..... | () | () |
| Excessive weight loss/gain... | () | () |
| Skin conditions | () | () |
| Arthritis | () | () |
| Diabetes..... | () | () |
| Prostate condition | () | () |

Comments:

Is this injury work related? _____ Have you reported it to your employer? _____ Is this injury related to an auto accident ? _____ (If yes give name of auto insurance of the car that you were in) Company _____ Policy # _____ Claim # _____

Do you have health insurance? () Yes () No Company _____

Claims mailing address _____ Policy # _____

Are you covered by any other group or individual policy through yourself or your spouse? () Yes () No

Claims mailing address _____ Spouse's Social Security # _____

Are you pregnant? () Yes () No () Possibly

Nearest relative not living with you _____

Address _____ Phone #: () _____ Relationship _____

Patient's Signature _____

Date _____