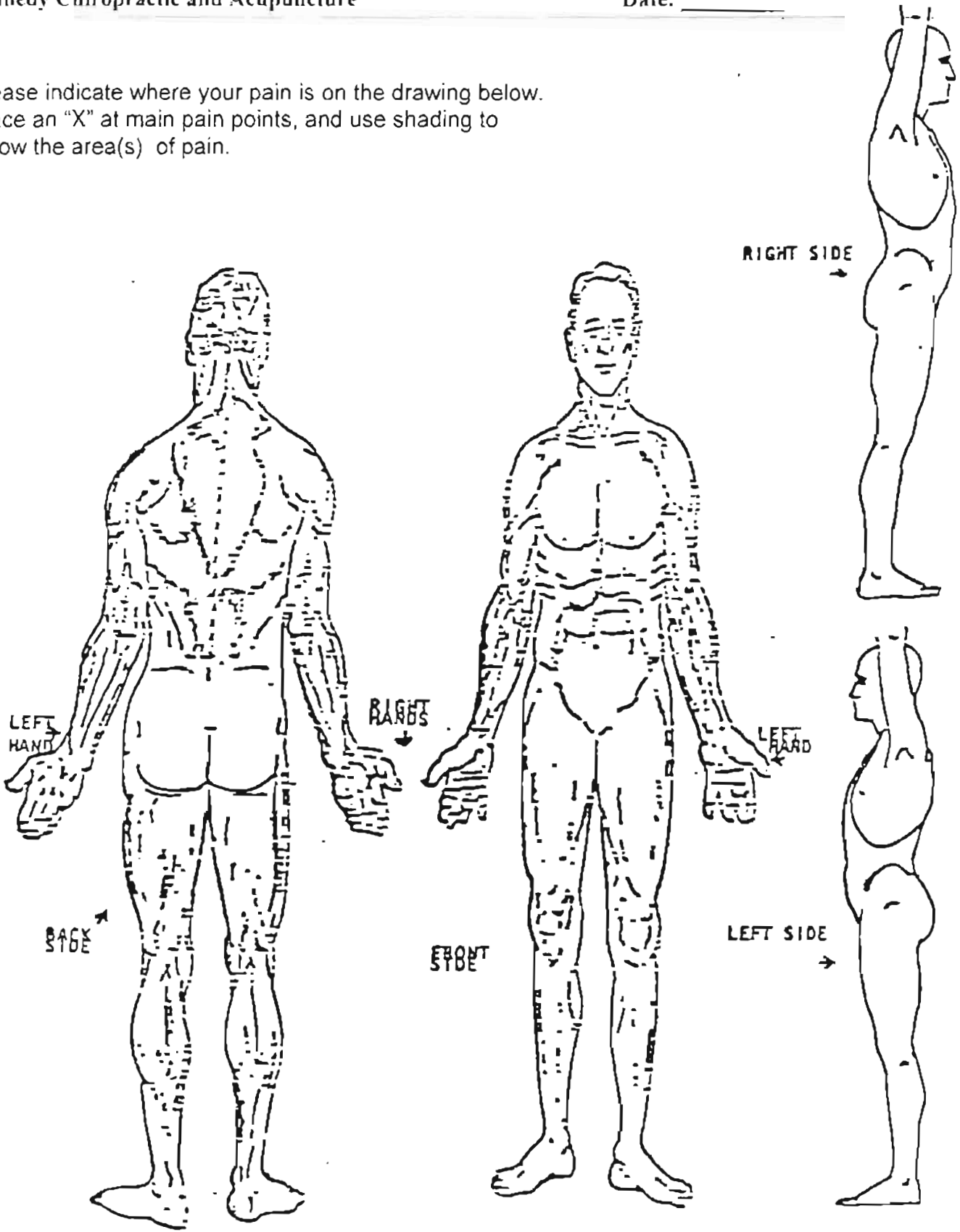


- Please indicate where your pain is on the drawing below.
- Place an "X" at main pain points, and use shading to show the area(s) of pain.



Signature: \_\_\_\_\_

Date: \_\_\_\_\_





13. The following items listed may increase, decrease or have no effect on your pain. Please mark the one that applies to you best. Leave blank if no effect.

	<u>Increases</u>	<u>Decreases</u>
Movement	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>
Distraction (TV, Movies, Reading)	<input type="checkbox"/>	<input type="checkbox"/>
Urination, Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>
Stress/Tension	<input type="checkbox"/>	<input type="checkbox"/>
Going to Work	<input type="checkbox"/>	<input type="checkbox"/>
Everything	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else that increases your pain? \_\_\_\_\_

Is there anything else that relieves your pain? \_\_\_\_\_

14. Since the injury your symptoms are:  better  worse  unchanged

15. At this time are your symptoms are:  better  improving  getting worse  unchanged

16. The following words represent degrees of pain severity.

0	none	5-6	distressing (fairly severe)
1-2	mild	7-8	very severe (horrible)
3-4	uncomfortable	9-10	unbearable (excruciating)

Write the number of the words from the above list that describes:

- \_\_\_\_\_ 1. Your pain as it usual feels  
 \_\_\_\_\_ 2. Your pain as it is right now.  
 \_\_\_\_\_ 3. Your pain at its worst.  
 \_\_\_\_\_ 4. Your pain when it hurts the least.

17. How many days a week do you experience pain?  daily  1-2  3-4  5-6  intermittent

### PRE-EXISTING STATUS

*(The purpose of this section is to understand how you were prior to your injury or illness.)*

18. Did you have any similar or previous problems?  yes  no
19. Were you under a physician's care or in therapy prior to the injury?  yes  no
20. Have you had any other significant disabling problems or accidents?  yes  no

## MEDICAL CARE

(The following questions are about the health care you have received for this illness.)

21. When did you first obtain medical attention? Date \_\_\_\_\_  
 Place \_\_\_\_\_ Doctor \_\_\_\_\_

22. Please check all the providers you have seen during this illness.  
 Below list their name and service.

Name	Specialty	Date	Role			
			Treating Physician	Consultant Only	IME	Currently seeing
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. **DIAGNOSTIC TESTS** (Please list all diagnostic tests you've had during this illness. Please give dates of those tests you've had and location.)  
 (x-ray, MRI, lab, CAT scan, bone scan, neuropsych testing, psychological consultation, visual testing, auditory (ear) testing, dental evaluation, functional capacity assessment, thermogram)

Test	Body Part	Date	Location	Results	Concur?
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> WNL <input type="checkbox"/> ? <input type="checkbox"/> Abn.	<input type="checkbox"/> Y <input type="checkbox"/> N

24. **TREATMENTS RECEIVED**

Have taken the following:	Yes	Makes Better	Makes Worse	No Effect	Currently
Pain killers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol (acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nonsteroidal anti-inflammatories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anti-depressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pills for your nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>Makes Better</u>	<u>Makes Worse</u>	<u>No Effect</u>	<u>Currently</u>
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strength and conditioning therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Hardening Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pool therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteopathic manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise (during)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise (after)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tens unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ionophoresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot tub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>					
Injections of pain killers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections of joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections of tendons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections of trigger points	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stellate ganglion block injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brytillium block injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guanethidine block injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>					
Sauna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Splints or braces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI joint brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthotics (Foot cushions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ splint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>					
Carpal tunnel operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disc operation of the neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disc operation of the low back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine fusion operation of the neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine fusion operation of low back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthroscopic operation of shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____					

25. Are there any remaining problems associated with the procedures performed?

### WORK HISTORY

(The purpose of this section is to understand how illness has effected your work and all about your past work experience and skills.)

A. The following questions refer to your employment at the time of your injury:

26. Employed by: \_\_\_\_\_

27. Job title: \_\_\_\_\_

28. Date hired: \_\_\_\_\_

29. Job description: \_\_\_\_\_  
\_\_\_\_\_

30. Salary: \_\_\_\_\_

31. Have you tried to return to work?  yes  no

32. If your pain/injury was resolved would you return to this job?  yes  no  
 part-time  full-time

B. The following questions refer to work NOW.

33. If not working, why? Date last worked: \_\_\_\_\_  
 too much pain  medical restrictions  can't concentrate  too tired  
 laid off

34. If you have returned to work:  
 full-time  part-time  regular job  modified job  different job

35. Comparing your job ability before you had injury/pain problem, what can you do?  
 as much as before  somewhat less than before  about half as much as before  
 much less than before  somewhat less than before  not do the job at all

36. Do you have work restrictions?  
 yes  no Explain: \_\_\_\_\_

C. Future goals and plans

37. Are you going to school?  yes  no  full-time  part-time

38. What would you like to do? \_\_\_\_\_

39. Do you have future plans? \_\_\_\_\_

ACTIVITIES OF DAILY LIVING/FUNCTIONAL STATUS

These questions are about how your symptoms and health effect your activities now.

a. Sexual function

interest \_\_\_\_\_

b. Social/Recreational

participation in group activities  
Now: \_\_\_\_\_  
Before: \_\_\_\_\_

sports/hobbies  
Now: \_\_\_\_\_  
Before: \_\_\_\_\_

What tasks are most difficult for you? \_\_\_\_\_

40. Please describe activities you do on an average day.  
 rest  watch TV  read  light chores  heavy chores  clean house  
 work  look for work  visit friends and family

SOCIAL/HABITS

41. 1) Do you use tobacco?  yes  no      Have you ever smoked?  yes  no  
If yes: How many years? \_\_\_\_\_      Packs per day \_\_\_\_\_  
When did you quit? \_\_\_\_\_      Do you want to stop? \_\_\_\_\_
- 2) Caffeine, please describe use.  
\_\_\_\_\_
- 3) Alcohol use: How much? \_\_\_\_\_  
How often? \_\_\_\_\_  
Does alcohol cause any problems? \_\_\_\_\_  
Were you alcoholic in the past? \_\_\_\_\_  
When do you drink? \_\_\_\_\_
- 4) Nonprescription drug use (Describe): \_\_\_\_\_
- 5) Exercise - Please describe in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6) Education completed:  
 elementary school       high school w/diploma or GED  
 college degree       advanced degree  
 vocational training \_\_\_\_\_
- 7) Family - Are you:  married  single  divorced  widower  separated
- Marriage:
- |        | <u>Dates</u> | <u>Children/Age</u> | <u>Why ended</u> |
|--------|--------------|---------------------|------------------|
| First  | _____        | _____               | _____            |
| Second | _____        | _____               | _____            |
| Third  | _____        | _____               | _____            |
- If you have children, where are they now? \_\_\_\_\_
- Overall, how happy are you with your family life?  
 extremely happy     happy     not happy     very unhappy

PAST/OTHER MEDICAL HISTORY

*(The purpose of this section is to understand your overall general medical history and health care status.)*

1) *Family Members' History*

If yes, Who?

- |                           |                              |                             |       |
|---------------------------|------------------------------|-----------------------------|-------|
| Similar problem to yours? | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |
| Disability                | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |
| Arthritis                 | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |
| Heart disease             | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |
| Diabetes                  | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |
| Drug abuse                | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |
| Alcoholism                | <input type="checkbox"/> yes | <input type="checkbox"/> no | _____ |

(Your Medical History)

2) Hospitalisations:

<u>Year</u>	<u>Illness/Operation</u>	<u>Remaining problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) Previous Trauma (automobile accident, fractures, strains, any other):

<u>Date</u>	<u>Injury/Accident</u>	<u>Remaining problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) Allergies (medication or environmental): \_\_\_\_\_

6) Medications (please all medications you take - even if only occasional)

<u>Medication</u>	<u>Dose</u>	<u>How often</u>	<u>When started</u>	<u>Why?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7) Previous worker's compensation or personal injury:

<u>Date</u>	<u>Injury</u>	<u>Company</u>	<u>PI/WC</u>	<u>Work time lost</u>	<u>Disability Rating</u>	<u>How settled</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

STRESS MANAGEMENT

42. After reading each symptom, write the number that best corresponds with how you felt during the past several days. Use this formula: 0=not at all; 1=somewhat; 2=moderately; and 3=a lot.

- (1)  Sadness: Have you been feeling blue or "down in the dumps"?
- (2)  Irritability, frustration: Have you been feeling resentful and angry a good deal of the time?
- (3)  Low self-esteem: Have you been feeling inadequate or worthless?
- (4)  Loss of interest in life: Have you lost interest in your career, hobbies or daily activities?
- (5)  Loss of interest in people: Have you lost interest in your friends, family or spouse?
- (6)  Loss of Motivation: Have you needed to push yourself hard to do things? Have you been procrastinating?

(7)  Guilt: Have you been blaming yourself for your weaknesses, shortcomings or mistakes?

(8)  Sleep changes:  Have you had difficulty falling asleep and sleeping soundly?  
Fatigue  Have you been excessively tired and sleeping too much?  
 falling asleep \_\_\_\_\_  
 quality of sleep \_\_\_\_\_  
 staying asleep \_\_\_\_\_  
 awakening early \_\_\_\_\_

total restful hours: \_\_\_\_\_

(9)  Loss of libido: Have you lost interest in sex? Are people whom you once found attractive no longer appealing to you?

(10)  Suicidal impulses: Have you thought that life is not worth living and that you would rather be dead? Have you been having suicidal fantasies or impulses or making suicide plans? (If your answer indicates that you have suicidal urges, you should immediately seek help from a mental health professional.)

43. With your present income are you?

- unable to pay your bills       able to pay for all necessities  
 comfortable                       destitute  
 worried about future income

44. What is the status of your legal proceedings?

- none filed       pending       resolved
- \_\_\_\_\_
- \_\_\_\_\_

45. Is your injury or pain affecting your relationship with:

your spouse?       yes  no \_\_\_\_\_

46. your children?       yes  no \_\_\_\_\_

47. your co-workers/friends?       yes  no \_\_\_\_\_

## MEDICAL REVIEW OF SYSTEMS

The following is a record of any symptoms you may have had in the past or are ongoing. Please check the appropriate boxes for each.

N = never    O = occasional    F = frequent

<u>General</u>	N	O	F	<u>Eyes</u>	N	O	F
feeling hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
hot/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Ears</u>			
chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				<u>Face/Throat</u>			
<u>Head/Neurologic</u>				sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
neck injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	problems swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pain on chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pain in your jaw(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
slurred speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	problems smelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
concentration problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Lungs</u>			
strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
carpal tunnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Bones/Joints</u>				shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cramps/spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rapid breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Heart</u>			
back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
chiropractic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rapid heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dislocations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath:			
osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	w/activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pain or numbness in:				leg cramps (walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	swollen feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Circulation</u>			
wrists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Skin</u>			
				pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>