Health ONE DISC Denver International Spine Center Physician Care℠

Phone: (303) 762-DISC (3472)
Fax: (303) 861-6219

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM ____/DD ____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ___-___-___ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____/DD ____/YYYY _____

Social Security Number ___-___-___ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY ____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

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GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

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PRESCRIPTION REFILL POLICY

- No prescriptions will be refilled on Fridays, Saturdays, Sundays or holidays
- We require a minimum of 72 hours to process prescription(s) renewal and/or pick-up requests
- The patient is responsible for knowing when medication(s) will need to be refilled (no early refills)
- Prescription phone-in/pick-up: Monday – Thursday during business hours ONLY (9 a.m. to 4:30 p.m.)
- Prescriptions will not be filled for unauthorized "walk-in" patients. Patients must call the office, as physicians and physician assistants may be inaccessible with surgery and inpatient needs
- Non-controlled/non-narcotic prescriptions require a follow-up appointment every 3-6 months
- Controlled substances/narcotic prescriptions require a follow-up appointment every 30-90 days
- New symptoms and/or events require a clinic appointment. Providers are unable to diagnose over the phone.
- Signed "controlled-substance/narcotic policy" forms are required in using narcotic/controlled medications
- No early refills if medications are overused/abused/misused. Patients must follow prescription directions.
- No medication/prescription will be replaced if lost, stolen, misplaced, overused
- Medications are for the prescribed individual's use only. It is illegal to "share" your medication.
- Patient must pick up his/her prescription(s) in person, unless pre-authorized by staff.
- All patients receiving narcotic medications are subject to random urine drug testing (UDT) to ensure safety and compliance (see Pain Management/Controlled Substance Agreement).
- We are under no obligation to prescribe controlled substances regardless of prior treatment.

These protocols are per the recommendations of the Colorado Board of Medical Examiners and the DEA.

I understand and accept the above protocols. Failure to comply may subject immediate termination of prescriptive medications.

Patient Name: _____ Date: _____/_____/_____

Signature: _____

Name of person picking up Rx (if not same): _____

It is required that the designated patient representative picking up the RX bring a valid government-issued photo ID

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FINANCIAL POLICY

We would like to thank you for choosing the **Denver International Spine Center** for your care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records upon request.

SERVICE

You are here to receive a service. There are charges associated with the services we provide. Services include, but are not limited to: consultation, evaluation, and procedures. Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, MRIs, CT Scans, and DEXA Scans)

MISSED APPOINTMENT/LATE CANCELLATION

Our office will call to confirm your/ your child's appointment two (2) business days prior to the appointment date. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour notice** for cancellations or rescheduling of appointments.

CHECK IN

We respect and value your time. ***If you are more than 15 minutes late for your appointment, we may need to reschedule.*** We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient manner while receiving the highest quality care.

ESTABLISHED PATIENTS: We request that **all** of our established patients **arrive 15 minutes prior** to their appointments for any paperwork process that may be required at check in.

NEW PATIENTS: If it is your first time to our office, **please arrive 45 minutes prior to your appointment time with your paper work completed**. If you were unable to complete the paperwork, we still request that you come in **60 minutes early** to ensure that appropriate paperwork is completed.

PAYMENT

For patients with a **co-pay** plan, payment is expected at the time of service. When you check in for the appointment, we will collect the amount indicated on your card unless otherwise instructed. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered such as **deductibles** and coinsurance are your responsibility and will be billed to you by our office. Payment is due with-in 30 days upon receipt.

SELF PAY

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by speaking with one of our staff. Once your bill is processed through our system there may be an additional balance due to us, or due back to you.

INSURANCE

All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility as the parent/guardian/patient to provide accurate and timely insurance information.

INSURANCE REFERRALS

It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office before an appointment can be made. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

I certify that I have read and fully understand the above statements.

Patient Name: _____ DOB: _____/_____/_____

Patient/Responsible Party Signature: _____Date:_____/_____/_____

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NEW PATIENT INFORMATION FORM

Please print all information. By fully completing this form, you allow us to serve you quickly and efficiently. If you already have completed this form in the last 3 months, please fill out just the first 2 pages and any items on the remaining pages that have changed since your last visit.

Date of Visit: _____ Date of Birth: _____/_____/_____ Age: _____

Patient Name:_____ ❑ Male ❑ Female

Address:_____

Phone: Cell: ( ) _____Home: ( ) _____ Work: ( ) _____

Email: _____

Referrals:
How were you referred to The Denver International Spine Center: ❑Physician ❑Patient /Friend ❑ Internet
❑ Workers Comp ❑ Insurance ❑ Radio /TV ❑ Emergency Room: _____❑ Other: _____
Referring Physician or Referral Source: _____

Address:_____

City:_____
Phone: ( )_____ Fax: ( )_____

Do you want your medical records sent to this physician? ❑ Yes ❑ No

Would you like your medical records sent to any other physicians (Name and address)

_____
_____
_____

Have you had spinal surgery in the past: (Check one) ❑ No ❑ Yes - How many times?_____

What type of surgery(s) was/were performed? ❑ Discectomy ❑ Laminectomy ❑ Fusion ❑ Unknown

❑ Other: _____ What spinal level? _____

What was the date of your most recent spine surgery? _____

Did you improve from your spine surgery procedure(s)? ❑ Yes ❑ No

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Patient Name (print):_____ **Date:**_____/ _____/_____

Reasons for Today's Visit:

Symptoms: ☐ BACK pain ☐LEG pain ☐ Neck pain ☐Arm pain ☐ Numbness ☐ Weakness ☐ Scoliosis

☐ Other _____

How long have you had your symptoms?_____

What caused your symptoms? ☐ Unknown ☐ Injury ☐ Other _____

Have your symptoms improved or worsened recently? ☐ Improved ☐ Worsened

When did and what caused your symptoms improve or worsen?_____

What % of your symptoms are in the BACK and LEG? (please check <u>one</u> box)	**What % of your symptoms are in each LEG? (please check <u>one</u> box)**
☐ Back 0%, Leg 100%	☐ No LEG symptoms
☐ Back 10%, Leg 90%	☐ Right 0%, Left 100%
☐ Back 25%, Leg 75%	☐ Right 10%, Left 90%
☐ Back 50%, Leg 50%	☐ Right 25%, Left 75%
☐ Back 75%, Leg 25%	☐ Right 50%, Left 50%
☐ Back 90%, Leg 10%	☐ Right 75%, Left 25%
☐ Back 100%, Leg 0%	☐ Right 90%, Left 10%
	☐ Right 100%, Left 0%

Where in your LEG do you have PAIN or TINGLING?		**Where in your LEG do you have NUMBNESS?**		**Where in your LEG do you have WEAKNESS?**	
Right	**Left**	**Right**	**Left**	**Right**	**Left**
☐ None	☐ None	☐ None	☐ None	☐ None	☐ None
☐ Buttock	☐ Buttock	☐ Buttock	☐ Buttock	☐ Buttock	☐ Buttock
☐ Thigh, back	☐ Thigh, back	☐ Thigh	☐ Thigh	☐ Thigh	☐ Thigh
☐ Thigh, front	☐ Thigh, front	☐ Calf	☐ Calf	☐ Calf	☐ Calf
☐ Calf	☐ Calf	☐ Ankle	☐ Ankle	☐ Ankle	☐ Ankle
☐ Foot	☐ Foot	☐ Foot /toes	☐ Foot/toes	☐ Foot	☐ Foot

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Patient Name (print):_____ **Date:**_____/ _____/_____

What % of your symptoms are in the NECK and ARM? (please check <u>one</u> box)	**What % of your symptoms are in each ARM? (please check <u>one</u> box)**
☐ Neck 0%, Arm 100%	☐ No ARM symptoms
☐ Neck 10%, Arm 90%	☐ Right 0%, Left 100%
☐ Neck 25%, Arm 75%	☐ Right 10%, Left 90%
☐ Neck 50%, Arm 50%	☐ Right 25%, Left 75%
☐ Neck 75%, Arm 25%	☐ Right 50%, Left 50%
☐ Neck 90%, Arm 10%	☐ Right 75%, Left 25%
☐ Neck 100%, Arm 0%	☐ Right 90%, Left 10% ☐ Right 100%, Left 10%

Where in your ARM do you have PAIN or TINGLING?	
Right	**Left**
☐ None	☐ None
☐ Upper back	☐ Upper back
☐ Shoulder	☐ Shoulder
☐ Upper arm	☐ Upper arm
☐ Forearm	☐ Forearm
☐ Hand	☐ Hand

Where in your ARM do you have NUMBNESS?	
Right	**Left**
☐ None	☐ None
☐ Upper arm	☐ Upper arm
☐ Forearm	☐ Forearm
☐ Thumb	☐ Thumb
☐ Index finger	☐ Index finger
☐ Ring/small	☐Ring/small

Where in your ARM do you have WEAKNESS?	
Right	**Left**
☐ None	☐ None
☐ Shoulder	☐ Shoulder
☐ Arm	☐ Arm
☐ Forearm	☐ Forearm
☐ Hands	☐ Hands

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Patient Name (print):_____ **Date:**_____/ _____/_____

BACK PAIN (circle number)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be

LEG PAIN (circle number)

☐ 0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be

NECK PAIN (circle number)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be

ARM PAIN (circle number)

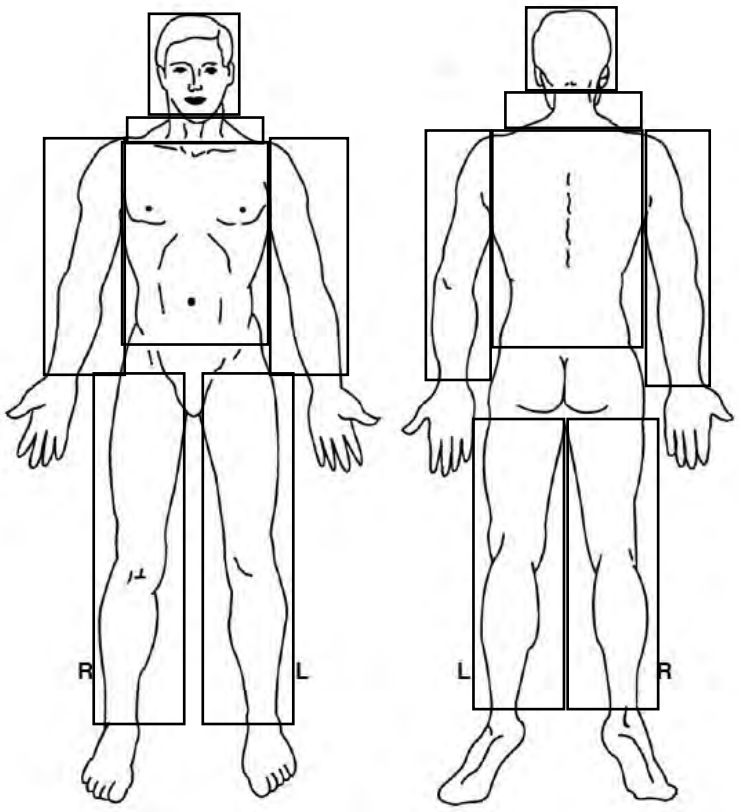
☐ 0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be

HEADACHE PAIN (circle number)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be



Please mark the areas on the diagram to the left where you are having symptoms and the location where the symptoms radiate.

Please use the following symbols to indicate the type of symptoms

Pain; ----------
Pins and needles; 0000000
Numbness; xxxxxxxxxxxx

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Patient Name (print):_____ **Date:**_____/ _____/_____

Back (answer if applicable):

How does your pain travel: ☐ Stays in my BACK ☐ Starts in the BACK and goes down the LEG

The worst position for pain is: ☐ No pain ☐ Sitting ☐ Standing ☐ Walking

Bending forward? ☐ Increases the pain ☐ Decreases the pain ☐ No effect

Lying down? ☐ Increases the pain ☐ Decreases the pain ☐ No effect

How many minutes can you STAND without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

How many minutes can you WALK without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

NECK (answer if applicable):

How does your pain travel: ☐ Stays in my NECK ☐ Starts in the NECK and goes down the ARM

Raising my arm: ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain

Moving my neck: ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain

Do your hands feel clumsy? ☐ Yes ☐ No

Do you have a problem with balance or tripping? ☐ Yes ☐ No

Do you have headaches in the back of your head? ☐ Yes ☐ No

Does coughing or sneezing increase your symptoms? ☐ Yes ☐ No

Do you have difficulty with bowel or bladder control? ☐ No ☐ Yes; since_____

Have you missed work because of your symptoms? ☐ No ☐ Yes; how much time _____

Previous treatments for my condition have included: (check any boxes that apply)

☐ **Nothing** (no medicines, therapy, manipulations, injections, or braces)

☐ Physical therapy: did it help relieve your symptoms?_____

☐ Chiropractic manipulation; did it help relieve your symptoms?_____

☐ Braces; did it help relieve your symptoms?_____

☐ Spine injections: How many injections have you had?_____
For how long did the injections relieve your pain?_____

☐ Surgery
How many surgeries have you had on your BACK?_____
Did surgery relieve your symptoms?_____

☐ Other treatment:_____

Previous doctors seen for your spine problem: ☐ None

Doctor	Specialty	City	Recommendations/Treatments

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Physical Examination (**FOR OFFICE USE ONLY** – Patients continue to the next page)

1. Constitutional:
   a. Vital Signs: Height _____Weight_____Pulse_____Resp_____
   b. Appearance: Nutrition_____Habitus_____
2. Neurological
   a. Orientation (PERSON/PLACE/TIME) [ ] Mood/ Affect (depression, anxiety, agitation) [ ]
3. SKIN (scars, ulcerations, etc; location); Neck_____Back_____BUE_____BLE_____
4. Eyes [ ]
5. Respiratory Effort [ ]
6. Adams forward bend: PT_____MT_____ TL/L_____
7. Pain Range of Motion Cervical/Thoracolumbar Spine (Yes/No)_____
8. Pain palpation Cervical/Thoracolumbar Spine (Yes/No; Location)_____
9. GAIT:: Tandem gait: (steady / unsteady); Able to Heel walk: (+ / -); Able to Toe walk: (+ / -)
10. Motor:

	Delt	Bi	Tri	WE	WF	FF	INT	Psoas	Quad	DF	EHL	PF	INV	EVER
R														
L														

11. Sensation: (symmetric, deficits, region of deficit): [ ]
12. DTR:

	Biceps	Triceps	BR	Knee	Ankles	Babinski	Hoffman's	Clonus	Umbilicus
R									
L									

13. Cardiovascular:

	DP	PT	Vascular changes	Swelling
R				
L				

Straight LEG raise	
Femoral Stretch Test	
Pain hip ROM	
Pain knee ROM	
Pain Shoulder ROM	
Coordination	
SI pain	
Rhomberg	
Carpal/Cubital tunnel exam	

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GENERAL INFORMATION

Height:_____ Weight: _____

MEDICAL HISTORY

Please choose all current and past medical conditions

❑ No medical problem
❑ High blood pressure
❑ Heart attack
❑ Abnormal heart rhythm
❑ Lung disease
❑ Tuberculosis
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Liver disease
❑ Hepatitis
❑ Multiple Bone Factures
❑ Diabetes
❑ Thyroid disease
❑ Stomach ulcers
❑ Irritable bowel
❑ Stroke
❑ Seizures
❑ Cancer – where? _____
❑ Kidney failure
❑ Kidney stones
❑ Osteoporosis
❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Bleeding disorders
❑ Anemia
❑Blood clots in legs/lung
❑ Endometriosis
❑ Ovarian cysts
❑ Anxiety
❑ Depression
❑ Schizophrenia
❑ Anorexia/bulimia
❑ Alcoholism
❑ Seen a psychiatrist
❑ HIV

Are you under a doctor's care for any other medical condition? ❑ Yes ❑ No If yes, please explain

SURGICAL HISTORY

Please choose all surgeries you have had ❑ None

❑ Spine-Neck
❑ Spine-Lower back
❑Brain
❑ Heart
❑ Angioplasty/ ❑ Stent
❑ Lung
❑ Gallbladder/ ❑ Stomach
❑ Appendix / ❑ Intestine
❑ Hernia/ ❑ Colon / ❑ Rectum
❑ Hysterectomy / ❑ C-section/
❑ Female
❑ Kidneys / ❑ Bladder / ❑ Urinary
❑ Prostate
❑ Shoulders / ❑ Arms/ ❑ Hands
❑ Hips/ ❑ Knees/ ❑ Legs /
❑ Feet
❑ Eyes
❑ Ears
❑ Throat / ❑ Tonsils
❑ Other:
_____
_____
_____

MEDICATION HISTORY

Current Medications ❑ None

Name Dose

_____
_____
_____
_____
_____
_____
_____

Allergies ❑ No known drug allergies

Medication Reaction

_____ _____
_____ _____
_____ _____

Are you allergic to latex? ❑ Yes ❑ No Complications with anesthesia ❑ Yes ❑ No

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SOCIAL HISTORY

1. Current work status: ❑ Working full duty ❑ Working restricted duty (Since_____) ❑ Retired

   ❑ Disabled (Since _____) ❑ Student ❑ Homemaker ❑ Unemployed

   Company: _____Occupation:_____ Title: _____

   How long have you worked for this company? _____

2. Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

3. Number of children: _____

4. I live: ❑ Alone ❑ With: _____

5. I live in a: ❑ House ❑ Apartment ❑ Assisted living ❑ Nursing home

6. Are you a cigarette smoker? ❑ Yes, now ❑ Never ❑Quit - How long ago did you quit? _____

   If you answered "yes" or "quit", how much do or did you smoke per day?

❑ Less than ½ pack ❑ ½ pack ❑ ¾ pack ❑ 1 pack ❑ More (How many?_____)

How old were you when you started smoking? _____

7. Are you a marijuana user? ❑ Yes, now ❑ Never ❑Quit - How long ago did you quit? _____

   If you answered "yes" or "quit", how much do or did you use per day? _____

8. Do you drink any alcoholic beverages? (Check one) ❑None ❑ 0 to 3 drinks per month ❑ 1 to 2 drinks per week
   ❑ 1 to 2 drinks per day ❑ 3 to 5 drinks per day ❑ More than 5 drinks per day. How many? _____
   Alcoholic in past? ❑Yes ❑ No

9. Have you ever had a problem with drug dependence? ❑Yes ❑No

10. Are there any law suits pending or contemplated related to your problem? ❑Yes ❑No

    If yes, please give your attorney's name and phone number: _____

11. Please write any additional information that you feel is important for us to know.

_____

_____

_____

_____

_____

(Continued on next page)

Patient Name (print):_____ **Date:**_____/ _____/_____

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Patient Name (print):_____ **Date:**_____/ _____/_____

FAMILY HISTORY

What illnesses run in your close family? ❑ None

❑ Scoliosis
❑ Spine disease
❑ Arthritis
❑ Heart disease
❑ High blood pressure
❑ Diabetes
❑ Cancer
❑ Bleeding disorder
❑ Mental illness
❑ Alcoholism
❑ Kidney disease
❑ Other:
_____
_____
_____

REVIEW OF SYSTEMS

Please check off any current or recent problems you have ❑ None

GENERAL:

____Unexpected Weight Loss
____Appetite change
____Fevers/Chills
____Night Sweats
____Marked Fatigue
____Difficulty Sleeping

EAR/NOSE/THROAT:

____Difficulty swallowing
____Hoarseness
____Loss of hearing
____Ear pain
____Nosebleeds
____Gum trouble

CARDIOVASCULAR:

____ Heart/Chest pain
____Abnormal heart beat
____Poor heart function

LUNG:

____Morning cough
____Shortness of breath
____Productive cough or sputum

EYES:

____Glasses
____Change of vision

DIGESTIVE:

____Nausea/Vomiting
____Stomach pain/Ulcers
____ Heartburn/acid stomach
____ Marked Fatigue
____Frequent diarrhea
____Frequent constipation
____Uncontrolled loss of stool
____Blood in stool
____Hemorrhoids

SKIN:

____ Frequent rashes
____Frequent itchiness
____Easy bruising
____Swollen ankles

NEUROLOGICAL:

____Seizures
____Blackouts/fainting
____ Tremor
____Headaches/migraines

MUSCLOSKELETAL:

____Joint pains/Swelling
____Back pain
____Neck pain
____Muscle Aches

GENITOURINARY:

____Burning on urination
____Difficulty starting urination
____Incontinence
____Pelvic pain
____Urinate at night more than once
____Unable to completely empty bladder

PSYCHIATRIC:

____ Depression
____Nervous exhaustion
____Anxiety
____Paranoia
____Obsessive/compulsive behavior