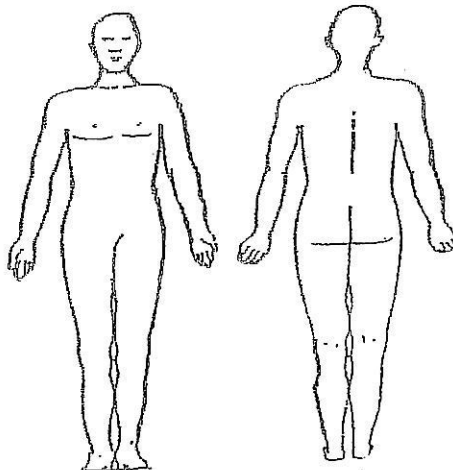


Is this an injury?  Yes  No      Did this occur at work?  Yes  No

Is so, are you filing workman's compensation?  Yes  No

If this is an injury, please state how it occurred. \_\_\_\_\_

Mark Area of Pain on the  
Diagram Below:



Date of onset \_\_\_/\_\_\_/\_\_\_

Have you had any other treatment for this condition?  Yes  No

Is so, what type? \_\_\_\_\_

Doctor? \_\_\_\_\_ Results:  None  Fair  Good

Do you have a hard time falling asleep at night?  Yes  No

Do you awaken often during the night?  Yes  No

Are you allergic to pollen?  Yes  No

Do you wear any inserts in your shoes or built up shoes?  Yes  No

### System Review

Please check those symptoms or conditions you have or have had in the last several years.

#### GENERAL

Irritability  
 Depression

Crave Sweets  
 Frequent sinus trouble

Abnormal hair loss or growth  
 Fatigue

#### HEAD

Headache  
 Migraine  
 Tension  
 Head feels heavy  
 Loss of memory

Fainting  
 Loss of smell  
 Epileptic seizures  
 Frequent ear infections  
 Inner ear trouble

Dizziness  
 Pain in ears  
 Ringing in ears

#### EYES

Blinded by lights

Light bothers eyes

Floating spots

#### NECK

Pain in neck

Stiff neck

Grating or popping sounds in neck