

MEDICAL SCREENING FORM

Name: _____

Date: _____

Circle YES or NO

Have you ever been told you have...

Cancer YES NO
Diabetes..... YES NO
High Blood Pressure YES NO
Heart Disease YES NO
Stroke/Heart Attack YES NO
Osteoporosis/Penia..... YES NO
Polio YES NO
Rheumatoid Arthritis YES NO
Pacemaker YES NO
Multiple Sclerosis YES NO
Infectious Diseases..... YES NO
Pins or Metal Implants YES NO
Osteoarthritis..... YES NO
Depression..... YES NO

In the past 3 months have you had or Do you experience...

Change in Health..... YES NO
Nausea/Vomiting YES NO
Fever/Chills/Sweats YES NO
Unexplained Weight changes YES NO
Numbness or Tingling..... YES NO
Change in Appetite YES NO
Difficulty Swallowing..... YES NO
Change in Bowel or Bladder Function YES NO
Shortness of Breath YES NO
Dizziness YES NO
Pain at night YES NO

Do you have a history of...

Allergies/Asthma YES NO
Headaches YES NO
Major Surgery YES NO
Describe: _____
Seizures YES NO

Are you currently...

Pregnant YES NO

Are your symptoms: (check one)

Getting worse The same Improving

Do you or have you in the past smoked tobacco?..... YES NO

Please list your current medications:

Have you had any medical imaging Performed for your current condition?

(Check all that apply)

X-rays MRI Other

Please label the diagram on the back of this page based on your current condition.

MEDICAL SCREENING FORM

Please use the diagram below to indicate where you feel symptoms right now.
Use the following key to indicate the different types of symptoms.

KEY:

Numbness

Pins & Needles
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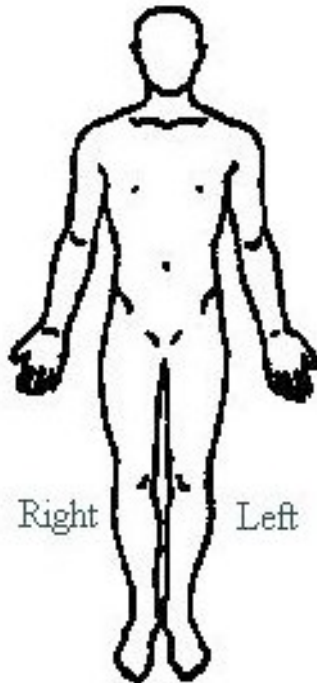
Burning
^^^^^^

Aching
xxxxxxx

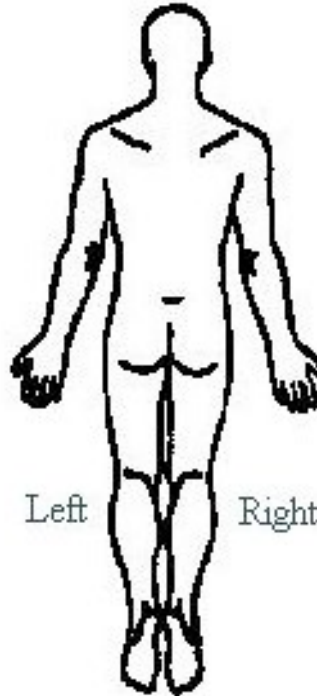
Stabbing
.....



Right



Front



Back



Left