CHECK the symptoms you have had in the past six months

Spinal
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Joint problems
- ☐ Disc problems
- ☐ Degeneration
- ☐ Stenosis
- ☐ Spondolysis
- ☐ Arthritis

Head & Neck
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Sinusitis
- ☐ Allergies
- ☐ Sensitive Teeth
- ☐ TMJ
- ☐ Stiff Neck

Shoulders, Arms, Hands
- ☐ Stiff Shoulders
- ☐ Pain Raising Arm
- ☐ Tennis Elbow
- ☐ Wrist Pain
- ☐ Carpal Tunnel
- ☐ Numbness

Lower Back & Legs
- ☐ Hip Pain
- ☐ Sciatica
- ☐ Painful Knees
- ☐ Leg Cramps
- ☐ Numbness
- ☐ Poor Circulation

Nerves & Functions
- ☐ Radiating Pain
- ☐ High Blood Pressure
- ☐ Short of Breath
- ☐ Indigestion
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Irritable Bowel
- ☐ Low energy
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Irritability
- ☐ Difficulty Sleeping
- ☐ Other __________

Children
- ☐ Frequent Colds
- ☐ Frequent Ear Infections
- ☐ Digestive Disturbances
- ☐ Growing Pains
- ☐ Attention Disorders
- ☐ Hyperactivity
- ☐ Asthma
- ☐ Seizures

Are conditions checked above LIMITING any of the following?

- ☐ Getting up and down
- ☐ Sitting
- ☐ Standing
- ☐ Bending Over
- ☐ Walking
- ☐ Running
- ☐ Sports
- ☐ Exercising
- ☐ Sleeping
- ☐ Being Energetic
- ☐ School
- ☐ Work
- ☐ Career
- ☐ Social Life
- ☐ Family Life
- ☐ Other __________

How long have you been living this way? Weeks (#) ____ Months (#) ____ Years (#) ____