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Diplomate in Nutrition - Board Certified 1989
Diplomate in Internal Disorders - Board Certified 1990

SYMPTOM HISTORY or MAJOR COMPLAINTS

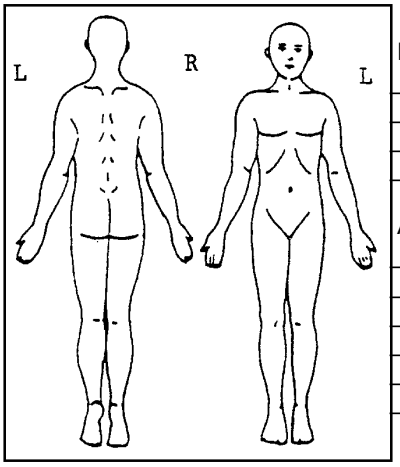
NAME: _____ **DATE:** _____

Using the drawings below, locate your areas of pain. Be specific, shade the involved areas and rate your pain in each area using the **0 - 10** scale. Add any other symptoms (like fatigue, nausea, etc.) on the lines in the area next to the figures.

What Are Your **PRESENT** Complaints and Symptoms?

[ ] Headaches	[ ] Head Seems Heavy	[ ] Sensitive to Light	[ ] Cold Feet
[ ] Neck Pain	[ ] Tingling (Pins & Needles) in Arms	[ ] Memory Loss	[ ] Stomach Pain
[ ] Neck Stiffness		[ ] Ringing in Ears	[ ] Indigestion
[ ] Sleeping Problems	[ ] Tingling in Legs	[ ] Face Flushes	[ ] Nausea
[ ] Upper Back Pain	[ ] Numbness of Arms/Hands	[ ] Buzzing in Ears	[ ] Night Sweats
[ ] Low Back Pain	[ ] Numbness of Legs/Feet	[ ] Loss of Balance	[ ] Fever
[ ] Nervousness	[ ] Shortness of Breath	[ ] Fainting	[ ] Coughing
[ ] Tension	[ ] Fatigue	[ ] Loss of Smell/Taste	[ ] Pain Down Legs
[ ] Irritability	[ ] Depression	[ ] Diarrhea	[ ] Other _____
[ ] Chest Pain	[ ] Constipation	[ ] Dizziness	[ ] _____
[ ] Cold Hands	[ ] _____	[ ] _____	[ ] _____

Please mark pain areas in figure below
on a pain scale of 0-10 (none to extreme): 0 __ __ __ __ __ __ __ __ __ __ 10



Frequency and Pain level of any areas noted on the figure to the left or above:

_____
_____
_____
_____

Any Other Symptoms:

_____
_____
_____
_____
_____
_____

(For Doctor's Use):

_____
_____
_____
_____
_____
_____
_____
_____