CLINICAL SYMPTOMS RECORD

Patient Name:________________________________ Date of Visit:____________

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU CURRENTLY EXPERIENCE:

Headache	Dizziness	Loss of Memory
Neck Pain	Mid Back Pain	Low Back Pain
Tingling in Arms	Tingling in Feet	Chest Pain
Ringing in Ears	Buzzing in Ears	Face Flushed
Loss of Balance	Loss of Smell	Fatigue
Depression	Sleeping Difficulties	Upset Stomach
Constipation	Tension	Irritability
Fever	Feet Cold	Hands Cold

Additional Symptoms not listed above:

Are you currently seeing another doctor for care of your current symptoms? If yes whom?

PAST CLINICAL HISTORY:

Any recent falls or accidents?

Any recent surgeries?

Medical Illnesses:

Current Prescription Medications:

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