HEALTHY BACK PLUS

NAME.....

ADDRESS.....

.....P/CODE.....

PHONE..... DOB.....

Please tick (✓) all conditions that apply now. Put a P for past conditions

Pain / stiffness
- □ neck / jaw
- □ back
- □ shoulder / arm / hand
- □ hip / leg / foot
- □ at night

Pins and needles
- □ arms / hands
- □ legs / feet

Numbness □
- □ arms / hands / fingers
- □ legs / feet / toes

Cold extremities
- □ hands
- □ legs / feet

Swelling of extremities
- □ legs / feet
- □ arms / hands
- □ weakness / clumsiness
- □ loss of balance
- □ headache
- □ dizziness / light headed
- □ heavy headed
- □ fainting
- □ light bothers eyes
- □ blurred vision
- □ visual impairment
- □ buzzing / ringing in ear
- □ hearing impairment
- □ speech impairment
- □ loss of smell / taste
- □ fatigue

Tension / stress / anxiety
- □ irritability / nervousness
- □ sleeping problems
- □ depression
- □ loss of memory
- □ convulsions / seizures

Skin conditions
- □ rashes
- □ Itching
- □ wounds
- □ infections
- □ bruise easily
- □ pain with cough or sneeze
- □ Sinus problems
- □ asthma
- □ chest pains
- □ heart problems/angina
- □ pacemaker
- □ high blood pressure
- □ low blood pressure
- □ varicose veins
- □ blood clots / DVT
- □ stroke (CVA)
- □ abdominal / digestive problems
- □ stomach upset / ulcers
- □ constipation
- □ diarrhoea
- □ diabetes mellitus
- □ cancer / tumours
- □ fever / sweats
- □ hepatitis B / C
- □ AIDS / ARC / HIV

Women only
- □ menstrual problems / PMS
- □ pregnant (now)
- □ contraceptive use
- □ pregnant (now)

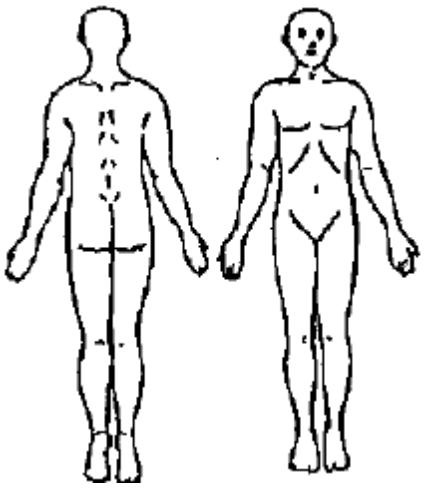
Rate your health at present out of 10. (10 = healthy. O = sick) ...../10

5. Do you experience any pain with this problem? □ Yes □ No

6. Rate the severity of pain you have experienced with this problem on the following pain scale.

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

No pain Extreme Pain



Please mark areas of pain if applicable

Does your current condition affect any of the following:	**Yes**	**No**	**How?**
Sleep			
Work or study			
Eating			
Social activities			
Relationships			
Sports and Recreational activities			

Do you have any known allergies?

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Surgical History/Current Medications

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