KLUCHARICH
WHOLE BODY HEALING
The Natural Way to Good Health!
843-664-0900

PERSONAL HEALTH APPRAISAL (P.H.A.)

Name _____ Phone (home/cell) _____ Address _____

Phone (business) _____ Occupation _____

Birthdate _____ Referred by _____

IMPORTANT The information requested In this form Is of vital importance to you and your health. It Is designed to help you understand your current state of health. Seeing your complete health picture helps you and your health care professional identify the natural medicines and therapies best suited to the dynamic restoration of YOUR health.

Read the questions carefully and score them on a 0 - 5 scale of intensity, 5 being the strongest.

If a question does not apply to you, score it a 0. If you are not sure and have a doubt about a question, or wish to clarify the answer, describe in the space available.

What priorities do you have for your health? List priorities, concerns, issues: _____

_____

_____

_____

Score the degree of severity of symptoms in each square below from 0 to 5.
0 - Never or No; 1 - Very mild or occasional; 2 - Mild; 3 - Moderate; 4 - Severe; 5 - Very severe or Yes

EXAMPLE: 3 Do you have headaches get hedaches on an empty stomach.

ALLERGY

1. _____ Do you have any allergies? If yes, please list: _____
2. _____ Do you live or work in a moldy environment? _____
3. _____ Are you sensitive to dairy products? _____
4. _____ Are you sensitive to fragrances or chemical smells? _____
5. _____ Are you sensitive to animal hair/dander? _____
6. _____ Do you have any food allergies? If yes, please list: _____
7. _____ Are your allergies worse in differenl areas of the country? Where? _____
8. _____ Do you have hay fever and/or seasonal allergies? _____
9. _____ Is your nose frequently stuffy? _____
10. _____ Have you been diagnosed with asthma? _____
11. _____ Have you been diagnosed with emphysema? _____
12. _____ Have you been diagnosed with bronchitis or pneumonia? _____

13. _____ Do you have chest pain or discomfort? _____
14. _____ Do you have post-nasal drip _____
15. _____ Do you spit up phlegm? _____
16. _____ Do you snore frequently or loudly? _____
17. _____ Do you have any other respiratory disorders? Explain: _____

CANCER SUPPORT

1. _____ Do have cancer or have you had it in the past? _____
2. _____ Do or did any of your immediate family members have cancer? If yes, describe in detail. _____

_____

CHILDREN

1. _____ Does your baby have colic? _____
2. _____ Does your child have problems with teething? _____
3. _____ Does your child wet the bed? _____
4. _____ Does your child have jaundice? _____
5. _____ Do you or your child have swollen tonsils? _____
6. _____ Does your child have swollen glands? Where? _____
7. _____ Does your child have attention deficit disorder? _____
8. _____ Is your child hyperactive? _____
9. _____ Does your child have any other learning disabilities? Explain: _____
10. _____ Does your child have recurring fears? _____
11. _____ Does your child have recurring fevers? _____
12. _____ Does your child have recurring nightmares? _____
13. _____ Does your child have recurring tummy aches? _____
14. _____ Does your child have abnormal growth patterns? _____
15. _____ Are there any other childhood disorders? Explain: _____
16. _____ Did or does your child have reactions from vaccinations? Explain: _____
17. _____ Does your child suffer from poor appetite? _____
18. _____ Does your child have excessive appetite? _____
19. _____ Is your child overweight? _____

CIRCULATION

1. _____ Do you have slurred or stuttered speech? _____
2. _____ Do you have confusion? _____
3. _____ Have you been diagnosed with a heart condition? _____
4. _____ Do you have low blood pressure? _____
5. _____ Do you have high blood pressure? _____
6. _____ Do you have circulatory problems? _____
7. _____ Are you often dizzy _____

8. _____ Do you get light headed when standing quickly? _____
9. _____ Do you have cold hands or feet? _____
10. _____ Do you experience spells of rapid heart beat? _____
11. _____ Are you aware of your heart skipping beats? _____
12. _____ What is going on in your life when your heart skips beats? _____
13. _____ Do you have nosebleeds? _____
14. _____ Do you have varicose or spider veins? _____
15. _____ Have you been diagnosed with phlebitis? _____
16. _____ Do you have any other circulatory disorders? Explain: _____

CLEANSING & DETOX

1. _____ Does acid accumulate in your body? _____
2. _____ Do you have any tumors or abnormal growths? _____
3. _____ Have you been diagnosed with a liver condition? _____
4. _____ Have you ever had chemotherapy or radiation treatment? _____
5. _____ Do you have pain or sensitivity in the lower right portion of the abdomen? _____
6. _____ Have you worked or lived in any toxic environments that you are aware of? Explain: _____
7. _____ Do you have any other toxic condition? Explain: _____
8. _____ Have you been exposed to toxic metals (tooth fillings, old plumbing or paint, frequent seafood consumption, etc?) _____
9. _____ Do you live in an area of heavy outdoor pollution? _____
10. _____ Does breathing the air in your house or workplace aggravate your symptoms? _____
11 _____ Are you frequently in contact with household chemicals and/or topical cosmetics? _____
12. _____ Do you have food allergies _____
13. _____ Do you live/work in a moldy environment? _____
14. _____ Are you aware of exposure to pesticides or herbicides? _____
15. _____ Are you aware of any reactions to food additives or preservatives? _____
16. _____ Do you have excessive thirst? _____
17. _____ Have you ever had reactions from vaccinations? Explain: _____
18. _____ Do you have frequent earaches or discharge from the ears? _____
19. _____ Do you have ringing in the ears or a loss of hearing? _____

CONSTITUTION

1. _____ Have you reached a plateau in your progress towards better health? _____
2. _____ Please describe any known genetic weaknesses within you or your family. _____
3. _____ Do you have any immune system challenges? _____
4. _____ Do you have any adverse reactions that are aggravated by cold/damp environments? _____
5. _____ Do you have any adverse reactions that are aggravated by cold/dry environments? _____
6. _____ Do you have any adverse reactions that are aggravated by hot/humid environments? _____
7. _____ Do you have any adverse reactions that are aggravated by hot/dry environments? _____

8. _____ Does your health suffer when the weather or seasons change? _____

DIGESTION

1. _____ Do you have problems with constipation? _____
2. _____ Do you use laxatives? _____
3. _____ Do you have frequent diarrhea? _____
4. _____ Do you have colitis _____
5. _____ Have you been diagnosed with a gall bladder condition? _____
6. _____ Do you have gall stones _____
7 _____ Do you have black stools? _____
8. _____ Do you have red or bloody stools? _____
9. _____ Do you have problems with heartburn? _____
10. _____ Do you have problems with hemorrhoids? _____
11. _____ Do you have problems with rectal fissures or polyps? _____
12. _____ Do you have indigestion? When _____
13. _____ Do you have problems with abdominal or lower GI gas? _____
14 _____ Do you have problems with bloating? _____
15. _____ Do you experience any pain or tenderness in your abdomen? _____
16. _____ Have you ever had intestinal worms, itchy nose or rectum? _____
17. _____ Are you frequently nauseated or vomit easily? _____
18. _____ Do you suffer from motion sickness? _____
19. _____ Have you been diagnosed with stomach ulcers? _____
20. _____ Do you have any other digestive disorders? _____
21. _____ Do you have frequent foul smelling lower gas? _____
22. _____ Do you have frequent foul smelling stools? _____
23. _____ Do you have frequent problems with upper gas, such as belching? _____

EYES

1. _____ Do you wear corrective lenses? _____
2. _____ Do you experience dry itchy, watery or red eyes? _____
3. _____ Do you have eye discomforts associated with allergies and hay fever? _____
4. _____ Are you troubled with conjunctivitis (pink eye)? _____
5. _____ Do you have styes? _____
6. _____ Do you have cataracts? _____
7. _____ Do you have eye stress? _____
8. _____ Do your eyes fatigue easily? _____
9. _____ Do you have macular degeneration? _____
10. _____ Do you have other eye conditions? Explain: _____

IMMUNE

1. _____ Are you bothered with viruses at various times during the year? _____
2. _____ Are you sensitive to chemicals? Explain: _____
3. _____ Are you oversensitive to the environment? _____
4. _____ Do you have recurring infections, virus, bacteria, fungus or other? Explain: _____
5. _____ Do you have colds or flu often? How often? _____
6. _____ Do you cough frequently _____
7. _____ Have you been diagnosed with Lyme disease? _____
8. _____ Do you have frequent laryngitis or hoarseness? _____
9. _____ Do you have fevers frequently? _____
10. _____ Do you have frequent sinusitis? _____
11. _____ Do you have frequent sore throats? _____
12. _____ Are your glands often swollen? _____
13. _____ Are your tonsils often swollen _____
14. _____ Do you have sinus headaches? _____
15. _____ Do you have yeast or fungal overgrowths and/or candida albicans infections? _____
16. _____ Do you have any other immune disorders? _____

MEN/WOMEN

1. _____ Do you have signs of premature aging such as wrinkles, grey hair, and body aches? _____
2. _____ Do you have prostate enlargement? _____
3. _____ Do you have dribbling after urination? _____
4. _____ Do you have an urgency to urinate? _____
5. _____ Do you have erectile dysfunction? _____
6. _____ Do you have premature ejaculations? _____
7. _____ Do you have decreased sexual desire? _____
8. _____ Do you have difficulty controlling sexual desire? _____
9. _____ Do you have any other male disorders? Explain: _____
10. _____ Do you have pre-menstrual syndrome? _____
11. _____ Do you retain fluid during your period? _____
12. _____ Do you have menstrual pain, cramps or irregularities? _____
13. _____ Do you have feminine discharge? _____
14. _____ Do you have vaginal pain or discomforts? _____
15. _____ Have you been diagnosed with endometriosis? _____
16. _____ Do you have breast cysts or lumps? _____
17. _____ Do you have breast mastitis? _____
18. _____ Do you have tender or sore nipples? _____
19. _____ Do you have frequent yeast infections? _____
20. _____ Are you going through or have symptoms of menopause? _____
21. _____ Do you frequently feel hot or perspire? _____

22. _____ Have you had a hysterectomy? _____
23. _____ Are you pregnant? _____
24. _____ Do you experience morning sickness with pregnancy? _____
25. _____ Have you had a miscarriage or are you prone to miscarry? _____
26. _____ Do you have problems with fertility? _____
27. _____ Is intercourse painful for you? _____
28. _____ Do you have diminished sexual desire? _____
29. _____ Do you have difficulty controlling sexual desire? _____
30. _____ Do you have any other female disorders? Explain: _____
31. _____ Have you been diagnosed with osteoporosis or weakened bones? _____
32. _____ Do you have heel spurs? _____
33. _____ Do you feel shaky when hungry? _____
34. _____ Are you a diabetic? What type? _____
35. _____ Have you ever been diagnosed with low blood sugar problems? _____
36. _____ Do you have increased urination and constipation associated with sugar consumption? _____

ORAL HEALTH

1. _____ Do your jaws pop or ache when eating? _____
2. _____ Do you have halitosis/bad breath? _____
3. _____ Do you have bleeding gums? _____
4. _____ Describe any dental work you've had: _____
5. _____ Do you have excessive plaque and tartar build-up on your teeth? _____
6. _____ Do you have teeth and/or gum problems? Describe: _____
7. _____ Do you have amalgam/metal fillings? How many? _____

PAIN

1. _____ Have you been diagnosed with rheumatoid arthritis? _____
2. _____ Have you been diagnosed with osteoarthritis? _____
3. _____ Does any part of your body experience numbness or tingling? Where? _____
4. _____ Do you have back or neck problems? Where? _____
5. _____ Do you have a spinal curvature? _____
6. _____ Do you suffer from muscle cramps_____
7. _____ Do you suffer from muscle spasms? _____
8. _____ Are your muscles frequently sore? _____
9. _____ Do you have muscle weakness? _____
10. _____ Are your joints stiff in the morning? _____
11. _____ Do you suffer from painful feet? _____
12. _____ Have you been diagnosed with gout? _____
13. _____ Do you have headaches? Explain: _____
14. _____ Do you have migraine headaches? Explain: _____

15. _____ Do you have sciatica? _____
16. _____ Do you bruise easily _____
17. _____ Have you been diagnosed with neurological disease? _____
18. _____ Do you have any other pain or injuries? Explain: _____
19. _____ Do you have tremors? _____
20. _____ Do you have tics (twitching)? _____
21. _____ Do you have ringing in the ears, hearing loss, or acute sensitivity to sounds? _____
22. _____ Do you suffer from restless leg syndrome? _____
23. _____ Do you suffer from leg cramps? _____

SKIN

1. _____ Do you have teenage acne? _____
2. _____ Do you have adult acne? _____
3. _____ Is your skin generally unhealthy and dry? _____
4. _____ Do you have any abnormal skin growths or discolorations? _____
5. _____ Do you have athlete's foot? _____
6. _____ Do you have insect bite reactions or allergies? _____
7. _____ Are insects attracted to you? _____
8. _____ Do you scar easily? _____
9. _____ Do you have any pain or discomfort in or around any scars? _____
10. _____ Do you have adhesions? Explain: _____
11. _____ Do you get cold sores _____
12. _____ Do you have warts? _____
13. _____ Do you have excess body perspiration? _____
14. _____ Do you have excess body odor? _____
15. _____ Do you have reactions to poison ivy, oak, or sumac? _____
16. _____ Do you have hair growth abnormalities? _____
17. _____ Do you have nail growth abnormalities? _____

SLEEP

1. _____ Do you feel weakness or exhaustion? _____
2. _____ Do you experience jet lag or problems with shift changes? _____
3. _____ Do you have insomnia? _____
4. _____ Do you have any abnormal sleep patterns? Describe: _____

SPORTS

1. _____ Are you interested in increasing muscular strength and/or bodybuilding? _____
2. _____ Do you have sports injuries? Explain: _____
3. _____ Do you have soreness, bruises, tightness and stiffness after sports activities? _____
4. _____ Are you interested in any sports enhancements? Explain: _____

URINARY

1. _____ Do you have frequent urination? _____
2. _____ Do you ever lose control of your bladder or dribble when sneezing or laughing? _____
3. _____ Do you have painful urination _____
4. _____ Do you have difficulty in starting the stream? _____
5. _____ Do you have frequent kidney or bladder infections? _____
6. _____ Do you have or have you ever had kidney stones? _____
7. _____ Do you have any other urinary tract disorders? _____

WEIGHT

1. _____ Are you overweight? Estimated lbs. overweight _____
2. _____ Are you underweight? Estimated lbs underweight _____
3. _____ How often do you exercise? ☐ Once a week ☐ Twice a week ☐ Three times a week ☐ Five times a week
   _____ More than 5 times a week
4. _____ What type of exercise do you do? ☐ Walking ☐ Running ☐ Jogging ☐ Aerobics ☐ Swimming
   _____ Other _____
5. _____ How much water do you drink daily? ☐ Less than 4 cups ☐ 4 - 8 cups ☐ More than 8 cups
6. _____ Do you crave sweets? _____
7. _____ Do you have an excessive appetite? _____
8. _____ Do you have a poor appetite? _____
9. _____ Do you desire to vomit after eating? _____
10. _____ Do you have an eating disorder? _____
11. _____ Do you eat when nervous_____
12. _____ Do you have edema or water retention? Where? _____
13. _____ Do you have any other weight disorders? Explain: _____

Please continue to the next page for your Mind & Body appraisal.

MIND & BODY

Please Follow These Instructions Carefully

IMPORTANT: The information requested in this form is of vital importance for your health facilitation. It is designed to help you understand your current state of health. This information is completely confidential and will be shared only between you and your doctor. Filling out your Mind & Body Health Appraisal with total honesty will allow your doctor to accurately identify the natural medicines and therapies best suited to the dynamic restoration of YOUR health.

Read each product question carefully and score only those questions which pertain to you on a 0-5 scale of intensity, 5 being the strongest. You do not have to have all the conditions listed, 1f there are specific conditions under a list that pertain to you please underline and score in the box.

Score the degree of severity of symptoms in each square below from 0 to 5.
0 - Never or No; 1 - Very mild or occasional; 2 - Mild; 3 - Moderate; 4 - Severe; 5 - Very severe

EXAMPLE: 3 Do you have tendencies of ADHD, hyperactivity, excitability, impulsiveness, or restlessness?

Addictaplex

_____ Do you have strong cravings or desires, general addictive lendenc1es, or expenence the negative effects of substance abuse?

Alcoholism

_____ Do you suffer from any emotional and physical effects of alcoholism, alcoholic tendencies or a predisposition to desire alcohol, associated with feelings of discontent and irritability?

Apathy

_____ Do you often experience feelings of indifference, apathy, lethargy, and/or lack of willpower?

Aversion to Change

_____ Do you have a fear of change, resistance to change. aversion to change, inflexible ideas, apprehension or dogmatic tendencies, or are you obstinate about change?

Aversion to Exertion

_____ Do you experience aversion to work, aversion to mental and/or physical exertion, languor, lack of will power, or despondency about business?

Burnout

_____ Are you currently experiencing physical, mental, emotional burnout from: overwork, long-term stress, lack of sleep, illness and nervousness, exhaustion, indifference, muscle weakness, and/or blood sugar imbalances?

Calloused

_____ Do you often feel hard-heaned, have fear of losing control, feelings of indifference, or have coldness toward others?

Chagrined

_____ Do you often feel discouraged. disappointed, humiliated, bitter, or intolerant of cnllcism, rejection, or contradiction?

Claustrophobia

_____ Do you have claustrophobic tendencies, episodes of panic and nervous tension?

Complaining

_____ Do you have tendencies to complain, grumble, mutter, whine, or spread negativity?

Criticize & Contradict

_____ Do you have tendencies to criticize and contradict, be fault-finding, insulting, censorious, and complain about others?

Deceitful

_____ Do you have difficulty with speaking the truth, or are you deceitful, sly, mistrustful, mischievous, or do you have hidden or irrational motives?

Easily Angered

_____ Are you often impatient, irritable, discontent, or easy to anger?

Egotistical

_____ Do you have tendencies toward excessive pride, arrogance, boasting, bragging, or vanity?

Envious

_____ Do you otten feel jealous, envious, selfish, or greedy?

Expressed Sexual Issues

_____ Do you experience tendencies toward lewdness and lasciviousness, sexual compulsiveness, exhibitionism, or inappropriate sexual excitement?

Extravagant

_____ Do you have tendencies to shop habitually, spend money excessively, live beyond your means. dress and act extravagantly, or display extreme eccentric behavior?

Fears & Nightmares

_____ Do you experience frightening dreams, night terrors, and/or restless tossing?

Fear & Phobia

_____ Do you often experience apprehension, fears or phobias of: heights, crowds, animals, people, places, being alone, public speaking, death, misfortune, ghosts, or the unknown?

First Aid for Mind & Body

_____ Have you recently experienced physical, mental, emotional stress and trauma such as: abrasions, bites, burns, bruises, strains, sprains, surgical procedures, tension, or shock?

Gambling

_____ Do you experience compulsive gambling and/or stealing, have a lottery or stock market obsession, or have reckless, impulsive, and extreme risk-taking behaviors?

Good Mood Enhancer

_____ Do you have mild depression or melancholy or display disinterest or discontent in daily life?

Gossipy

_____ Do you have tendencies to gossip, talk incessantly, be hasty, indiscreet, meddlesome, or feel uneasy during silence?

Grief

_____ Do you often feel grief, despair, hopelessness, worry, or despondency?

Guilt

_____ Do you often have feelings of guilt, remorse, heavy conscience, or tormenting thoughts?

Heart Ache

_____ Do you feel disappointed from lost love, have a heavy heart and grief, or feel discouraged, sad, dejected, or overly-sympathetic?

Hyperactive

_____ Have you been diagnosed with ADHD, hyperactivity, excitability, impulsiveness, or restless tendencies?

Hypochondria

_____ Do you often experience anxieties, worry, and apprehension regarding your health?

Immature

_____ Do you often act out childish behaviors, or fantasies, .have temper tantrums, or feel awkward?

Indecision

_____ Do you have tendencies of indecisiveness, irresolution, dissatisfaction, aversion to responsibility, and avoidance of high-pressure situations?

Insecurity

_____ Do you have feelings of inadequacy, nervousness, or apprehension?

Intense Anxiety

_____ Do you experience anxiety attacks, hysteria, anguish, apprehension, fear, or despair?

Lonely

_____ Do you have feelings of loneliness, tearfulness, despondency, desire for sympathy and/or company?

Melancholic

_____ Do you often experience feelings of depression, melancholy, discontent, ill-humor, or gloominess?

Mental Alertness for Seniors

_____ Are you experiencing age-related confusion, forgetfulness, depressed vitality, or loss of confidence?

Mood Changes

_____ Do you often experience mood changes from extreme joy to sadness. and/or have manic-depressive, or bipolar tendencies?

Neglectful

_____ Do you ever experience self-neglect, untidiness, aversion toward domestic duties, or indifference toward home matters or personal appearance?

Nostalgia

_____ Do you often feel homesick, nostalgic, have excessive sentimentality, sadness, or feelings of isolation?

Obsessions/Compulsions

_____ Do you often have anxiety, compulsive behaviors, obsessive thoughts, or peculiar mental impulses?

Overly-Sensitive

_____ Do you have tendencies to be overly sensitive. take offense, feel vulnerable, or cry easily?

Paranoid

_____ Are you often distrustful, have unfounded anxiety, skepticism, suspiciousness, or paranoia?

Perfectionism

_____ Do you have perfectionist tendencies, fear of failure, worry, inquietude, overly-cautious and conscientious tendencies?

Personality Changes

_____ Do you experience confusion over your identity, or have maniacal impulses, or an impulsive desire to harm oneself or others?

Physical Anger

_____ Do you often experience feelings of rage, have violent tendencies, or a volatile temper?

Prejudiced

_____ Do you have feelings of separateness, repressed fears, bias, or arrogant tendencies?

Procrastination

_____ Do you have tendencies to procrastinate, leave tasks incomplete, avoid responsibility, and lose track of time?

Religious Issues

_____ Do you ever experience religious melancholy, mania, alienation and/or fanaticism, feelings of unworthiness for salvation, selfcondemnation, or deprivation?

Repressed Sexual Issues

_____ Do you often feel sexually repressed or have negativity toward sexual matters, guilt over sexual issues or guilt over the effects of sexual abuse?

Reserved

_____ Do you tend to avoid social interaction, have a mild and reserved disposition, have sensitivity to noise or sensory overload, or tend to be verbally timid?

Restless Mind

_____ Do you have ADHD. a hyperactive mind, difficulty concentrating, forgetfulness, and/or difficulty reading and writing?

Seasonal Affective Disorder

_____ During extended rainy seasons or winter time - do you experience mild depression, drowsiness, fatigue, sugar cravings, irritability, difficulty concentrating, or avoidance of social situations?

Self-Abuse

_____ Do you often internalize anger, feel self-contempt or dissatisfaction with life, and/or have violent thoughts or actions, or consider self-inflicted violence?

Self-Pity

_____ Do you experience tendencies to pity yourself, feel unfortunate, discontented, or desire sympathy or-consolation?

Serious

_____ Do you often feel serious, firm, stoic, and/or have an aversion to laughter and amusement?

Sexual Identity

_____ Do you ever feel confusion about your sexual identity, have sexual guilt or depression, or deny your sexuality?

Shy

_____ Do you have tendencies towards timidity, shyness, lack of self-confidence, passivity, embarrass easily, or have feelings of inferiority and inadequacy, or susceptibility to peer pressure?

Sluggish Mind

_____ Do you experience absent-mindedness, confusion, forgetfulness, slow perception or comprehension?

Smoke Control

_____ Do you often crave tobacco in any form such as cigarettes, cigars, or chew?

Spaced-Out

_____ Do you have a tendency to daydream, reminisce, be absentminded, or be unobservant?

Stubborn & Contentious

_____ Do you have tendencies toward defiance, irritability, or stubbornness?

Stress Control

_____ Do you generally feel stress-induced states including: nervous tension, minor anxiety, fearfulness, or oversensitivity?

Verbal Anger

_____ Do you often curse, swear, use violent language, scold, insult, yell and scream, become rude and/or derogatory?

Vindictive

_____ Do you often experience feelings of vindictiveness, resentfulness, contempt, excessive irritability, or cruelty?

Please continue to the next page.

OTHER

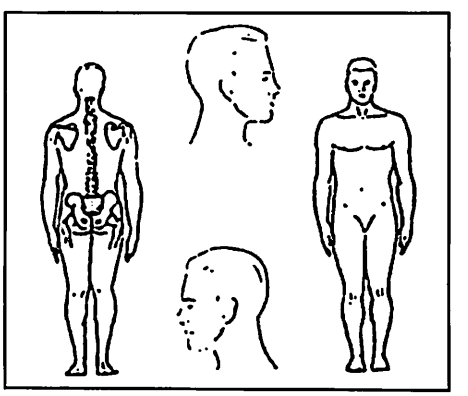
1. List all nutritional supplements, home remedies, etc. you have tried and their results. Mark what you are now taking.

2. Have you taken many over-the-counter (OTC) medicines over the years? _____
3. List any prescription drugs you have taken in the past: _____

4. List any prescription drug(s) you are taking now, how long you've taken them, and the condition you are taking them for: _____

5. Please feel free to write any personal information that you feel to be important to your health and well-being. This information is necessary for us to provide you with the highest quality health care possible. _____

6. Knowing the major health problems of your immediate family will assist us in understanding your health pattern. Report diseases, reasons for hospitalization, and/or cause of death.



1. _____ Please mark your areas of pain on the figures at right.
2. Describe the pain: _____

The information I have provided is to the best of my knowledge, accurate and true.

Signature of Patient or Guardian: _____ Date: _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE