**BEYOND DISEASE**

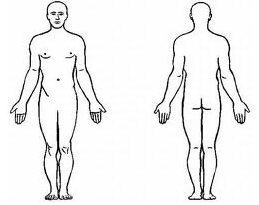
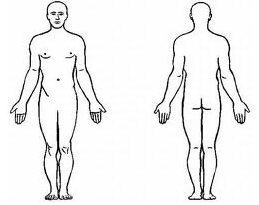
Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and the possibility of being accepted for care.

**Check any of the following diseases you have had:**

|  |  |  |  |
| --- | --- | --- | --- |
| * Appendicitis | * Malaria | * Chicken Pox | * Alcoholism |
| * Scarlet Fever | * Tuberculosis | * Diabetes | * Venereal Infection |
| * Diphtheria | * Whooping Cough | * Cancer | * Arthritis |
| * Typhoid Fever | * Anemia | * Heart Disease | * Epilepsy |
| * Pneumonia | * Measles | * Goiter | * Mental Disorder |
| * Rheumatic Fever | * Mumps | * Influenza | * Lumbago |
| * Polio | * Small Pox | * Pleurisy | * Eczema |

|  |  |  |
| --- | --- | --- |
| * Low Back Pain | * Fever | * Ear aches |
| * Pain between Shoulders | * Headaches | * Hearing difficulty |
| * Neck Pain | * Poor / Excessive Appetite | * Stuffy nose |
| * Arm Pain | * Excessive Thirst | * Menstrual Irregularity |
| * Joint Pain / Stiffness | * Frequent Nausea | * Menstrual Cramping |
| * Walking problems | * Vomiting | * Vaginal pain / infections |
| * Difficulty Chewing / Clicking Jaw | * Diarrhea | * Breast pain / lumps |
| * Numbness | * Constipation | * Prostate / sexual dysfunction |
| * Paralysis | * Hemorrhoids | * Genital herpes |
| * Dizziness | * Abdominal Cramps |  |
| * Forgetfulness | * Gas / Bloating after meals | **FEMALES ONLY** |
| * Confusion / Depression | * Heartburn | When was your last period? |
| * Fainting | * Black / Bloody stool | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Convulsions | * Colitis | Are you pregnant? |
| * Cold / Tingling Extremities | * Bladder trouble | |  |  |  | | --- | --- | --- | | * Yes | * No | * Maybe | |
| * Allergies | * Liver trouble |
| * Loss of Sleep | * Gall Bladder problems |
| * Weight trouble | * Short breath |
| * Painful / excessive urination | * Blood pressure problems |
| * Discoloured urine | * Irregular heartbeat |
| * Chest pain | * Heart Problems |
| * Lung problems / congestion | * Varicose veins |
| * Ankle swelling | * Vision problems |
| * Dental Problems | * Sore throat |

**Check any of the following you have had in the past 6 months:**



Please mark on the diagram the area of your discomfort.

I hereby authorize Beyond Physical to treat my condition, as he/she deems appropriate through use of therapy and additional procedures as are considered therapeutically necessary in the course of said treatment. I hereby certify that I have read and understand thus authorization for treatment. Beyond Physical will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

**Patient’s Signiature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian or Spouse’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_