

ACCT#

PATIENT INFORMATION

Date _____ Name _____

DOB _____ Age _____ Gender _____ Height _____ Weight _____

Head of Household Parent Spouse Child

Address _____ City / State / Zip _____

Telephone Home/Cell (____) _____ — _____ Work(____) _____ — _____

Email _____ Employer _____

Occupation _____

Whom referred you to the office? _____

Emergency Contact _____

Has anyone else in your family been seen in The West Clinic? _____

INSURANCE

Some people ask why we don't take insurance as payment. Fair Question, here is the answer straight from the government: Medicare Guidelines, Section 2251.3: "a treatment plan that seeks to prevent disease, Promote health, and Prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition is deemed NOT MEDICALLY NECESSARY"... This means that third party payers, (Blue Cross, Blue Shield, Aetna, United) now have government permission to deny health insurance claims.

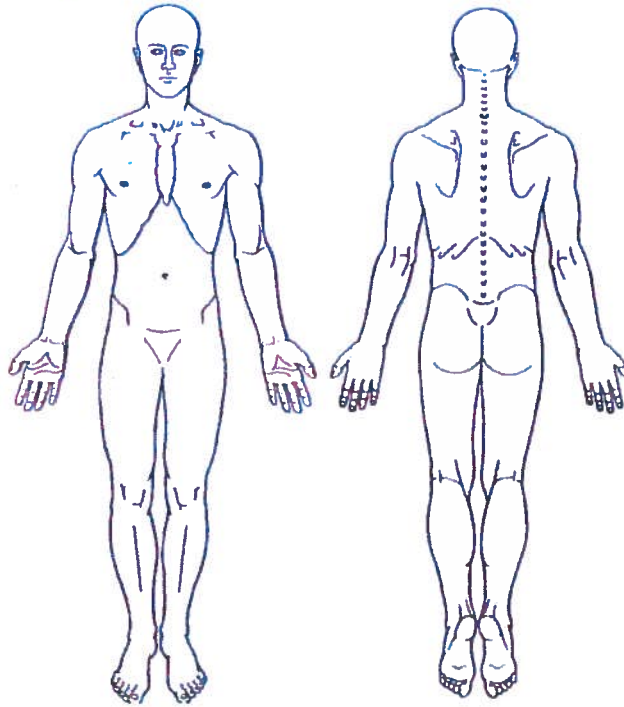
The Cutting edge, Outside the box approaches we take in addressing issues related to your condition are not covered by Medicare and Medicaid, and most insurance plans we've worked with in the past have also turned down claims for some of the procedures we do in this clinic. Therefore, we are no longer contracted with them. Insurance companies can be very restrictive in the types of options you might have available, Moving outside of the metaphorical box of approaches that insurance limits you to allow for the cause(s) of your condition to be determined, rather than simply offer options to continue treating the symptoms. When you begin to operate outside of insurance limited health care, you are able to determine how the other "outside-the-box" categories are affecting your health. Bridging the gaps between symptoms from various systems in the body, determining auto-immune triggers, and discovering other deficiencies that are contributing to your condition are also made possible when going beyond the medical standard of care.

PURPOSE OF VISIT AND INJURY INFORMATION

What services are you expecting? *(Circle all that apply)*

- | | | |
|--------------|-----------------|-----------------|
| IV | HCT | Asyra |
| Prolozone | Hormone Consult | Frankenhauser |
| Consultation | Weight | Crown of Thorns |
| Neural | Microscope | Other: _____ |

Please mark where it hurts:



When did the problem start? _____

What makes it feel better? _____

What makes it feel worse? _____

Does it hurt more in the: Morning Evening

Wheredoes the pain go? _____

Do you attribute your condition to a particular accident or illness (Please indicate a date)

Please List any other relevant health problems

Major Illnesses

Accidents or Major Trauma (Please indicate location of any significant scars)

Current Prescription medications (Names and Doses)

Allergies/sensitivities: Foods, Environmental, etc.

Have you been exposed to occupational chemicals? (asbestos, fertilizer, toxic fumes, etc.)

How Active are you? Do you exercise consistently?

Please list any vitamins, minerals, herbal formulas, or other supplements you are taking.
(Name, Manufacturer, and dose)

PATIENT CONDITIONS OF TREATMENT AND INFORMED CONSENT TO TREAT

Clinic Treatment(s)

This document is a binding agreement (the "Agreement") between The West Clinic, Dr Jason West, and/or (We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

- 1. Consent for Treatment.** You hereby consent to and authorize Us to provide You with health care treatment, including without limitation medical, diagnostic, nutritional treatment, Intravenous Micronutrient Therapy, Prolotherapy and Prolozone (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.
- 2. Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis and treatments may consist in whole or part of experimental procedures and methods, including without limit Intravenous Micronutrient Therapy, Prolotherapy and Mesotherapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. You acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. We have informed you that the Treatments MAY alter, address or decrease you pain, symptoms or complaints, but also may have no effect.
- 3. Risks, Side Effects, Complication.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation infection; swelling; increased pain; bleeding; scarring; scar or wound enlargement; keloid formation; asymmetry; temporary or permanent alteration in sensation; allergic reaction; discoloration; the need for additional surgery; soreness, itching, infection, injury to nerves, internally and externally leaking fluid and scaring at injection sites (all of which except the leaking fluid may be permanent); a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments; spinal cord injuries, Pneumothorax (air on the outside of the lung), paralysis, dizziness, numbness, no benefit from Treatments; or other serious or debilitating injuries or death.
- 4. Description of Treatments.** You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to you when we actually administer the Treatments.
- 5. Health Care Staff.** You are aware that among those who attend you on our behalf are medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedure and Treatments.
- 6. Information You Provide Us.** You have provided Us with a Complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with a complete list of all known allergies you may have, and all allergic or adverse reactions you have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete and up-to-date to the best of Your knowledge.
- 7. Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any question about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.
- 8. Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action.
- 9. Miscellaneous.** You agree that this Agreement constitutes the entire agreement between you and us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by you. This Agreement shall be binding on you and your successors, heirs, legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed Only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Idaho without regard to any choice of law principal. Any dispute between you and Us shall be adjudicated in state of federal court in Pocatello, Idaho, and You submit to the jurisdiction of any such court.

IMPORTANT MEDICAL LIABILITY INFORMATION AND AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION

We realize that the cost of malpractice insurance has risen to unacceptable levels. Dr. West and the staff are consulting with legal, insurance, riskmanagement, and other professionals to try and resolve this issue. Until it is resolved, Dr. West believes his patients should know that some of the procedures that are offered may not be insured for medical liability.

For the present, the only options are to close the clinic or to continue using some of these uninsured protocols and procedures while trying to resolve this problem. In deciding to continue, Drs. West will be instituting changes in his practice to more closely manage liability risk, but the intention is to continue to provide high quality Integrative Medicine.

Despite the best of care and intention, errors may occur, and medical errors may lead to harm. As part of our interim liability risk management policy, all patients and/or their legal guardians are now asked to sign a copy of this form attesting to the fact that they are aware that Drs. West may not have medical liability malpractice insurance for some procedures and protocols.

In addition, we must now require that all patients formally agree to utilize alternative dispute resolution conditioning of a two-step process: First, mediation, and second, if necessary, binding arbitration. This process would be instead of litigation and cover any and all legal disputes involving any professional actions of Dr. West and/or the staff of West Clinic. This means that you are agreeing to any and all disputes relating to health/medical care that is provided by Dr. West and/or the staff of West Clinic first to mediation, and if no resolution is achieved by mediation, then to bringing arbitration to be determined by a single arbitrator. The rules of the American Arbitration Association shall govern the mediation and binding arbitration and all proceedings shall be conducted pursuant to the rules of the American Arbitration Association.

These alternative dispute resolution methods are quicker and more cost effective in reaching an equitable solution for all parties involved. Because of the extreme overcrowding of the Court system and very high costs of litigation, these alternative dispute resolution methods are being increasingly employed as an alternative to the more costly and slower method of litigation by the judicial system.

The parties shall split the costs of mediating and disputes equally. Any attorney's fees incurred during mediation shall become a subject of the mediation and the parties will attempt to resolve attorney's fees during the mediation. The costs of binding arbitration shall be split between the parties equally and the arbitrator shall be empowered to award attorney's fees to the prevailing party.

Further, you agree that this agreement shall be governed by, construed, and enforced in accordance with the laws of the State of Idaho and subject to the jurisdiction of the First Judicial District Court of the State of Idaho in and/or Pocatello.

Dr. West understands that some may feel uncomfortable in signing this form. If that is the case, please do NOT sign until you discuss this with an attorney. Although Dr. West and the team will not be able to provide any professional services to patients who choose not to sign, we will provide any medical records we have in our profession to you free of charge so that you can select the healthcare practitioner of your choice for your continued care.

BY SIGNING THIS FORM(S), YOU ARE FORMALLY AGREEING TO ABIDE BY THE TERMS DESCRIBED IN THIS DOCUMENT.

RESEARCH POLICY

Dear Patient,

It is our commitment to our patients to provide the best health history, questionnaires, diagnostic procedures, laboratory tests, and clinical exams (orthopedic, neurological, and clinical observation) that we know. This is completely consistent with the Idaho Chiropractic, Naturopathic and Acupuncture Laws. Specifically Idaho Code Section 54-703, 54-5104, and 54-4702.

- 54703 - The practice of chiropractic means: to investigate, examine, and diagnose for any human disease, ailment, injury, infirmity, deformity, or other condition;
- 54-4702. A naturopathic physician may use physical and laboratory examinations consistent with naturopathic medical education and training for diagnostic purposes.
- "Acupuncture" means that theory of health care developed from traditional and modern Oriental medical philosophies that employs diagnosis and treatment of conditions of the human body based upon stimulation of specific acupuncture points on meridians of the human body for the promotion, maintenance, and restoration of health and for the prevention of disease. Therapies within the scope of acupuncture include manual, mechanical, thermal, electrical and electromagnetic treatment of such specific indicated points. Adjunctive therapies included in, but not exclusive to, acupuncture include herbal and nutritional treatments, therapeutic exercise and other therapies based on traditional and modern Oriental medical theory.

The Government (State & Federal) creates policies and guidelines that are subject to change without notice that may carry sanctions and penalties unless the facility is involved in research. This facility participates in research. The purpose of this document is to inform you that it is possible that some of the assessments or procedures at this office are investigational and research oriented and that you are participating in research regarding your health.

Privacy Policy - The West Clinic will not release any information that may potentially identify you regarding any research project. By signing below, I am stating my understanding that this facility participates in research and that my privacy is inviolable.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. you may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the consent to treat Medical Liability Research Policy and Privacy Practice.

Please print your name for all documents.

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (please provide specific details)

Employee signature

Date

*HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.*

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____
 Birth Date ____ / ____ / ____ Approx Weight _____ Sex: Male Female
 Pulse: Recumbent _____ Standing _____ Vegetarian Gluten-free
 Blood pressure: Recumbent ____ / ____ Standing ____ / ____ Ragland's Test is Positive

INSTRUCTIONS: Fill in only the circles which apply to you.

- ○ ○ MILD symptoms (occurs rarely).
- ● ○ MODERATE symptoms (occurs several times a month).
- ○ ● SEVERE symptoms (occurs almost constantly)
- ○ ○ Leave circles **BLANK** if they don't apply to you!

1 2 3

1 2 3 GROUP 1

- 1 ○ ○ ○ Acid foods upset
- 2 ○ ○ ○ Get chilled often
- 3 ○ ○ ○ "Lump" in throat
- 4 ○ ○ ○ Dry mouth-eyes-nose
- 5 ○ ○ ○ Pulse speeds after meal
- 6 ○ ○ ○ Keyed up - fail to calm
- 7 ○ ○ ○ Gag occasionally
- 8 ○ ○ ○ Unable to relax; startles easily
- 9 ○ ○ ○ Extremities cold, clammy
- 10 ○ ○ ○ Strong light irritates
- 11 ○ ○ ○ Occasionally weak urine flow
- 12 ○ ○ ○ Heart pounds after retiring
- 13 ○ ○ ○ "Nervous" stomach
- 14 ○ ○ ○ Appetite reduced occasionally
- 15 ○ ○ ○ Cold sweats often
- 16 ○ ○ ○ Get heated easily
- 17 ○ ○ ○ Nerve discomfort
- 18 ○ ○ ○ Staring, blinks little
- 19 ○ ○ ○ Sour stomach frequent

GROUP 2

- 20 ○ ○ ○ Joint stiffness on arising
- 21 ○ ○ ○ Muscle-leg-toe cramps at night
- 22 ○ ○ ○ "Butterfly" stomach, cramps
- 23 ○ ○ ○ Eyes or nose watery
- 24 ○ ○ ○ Eyes blink often
- 25 ○ ○ ○ Eyelids swollen, puffy
- 26 ○ ○ ○ Indigestion soon after meals
- 27 ○ ○ ○ Always seems hungry; feels "lightheaded" often
- 28 ○ ○ ○ Digestion rapid
- 29 ○ ○ ○ Vomit occasionally
- 30 ○ ○ ○ Hoarseness frequent
- 31 ○ ○ ○ Uneven breathing
- 32 ○ ○ ○ Pulse slow
- 33 ○ ○ ○ Gagging reflex slow
- 34 ○ ○ ○ Difficulty swallowing
- 35 ○ ○ ○ Temporary constipation or diarrhea
- 36 ○ ○ ○ "Slow starter"
- 37 ○ ○ ○ Get "chilled"
- 38 ○ ○ ○ Perspire easily
- 39 ○ ○ ○ Sensitive to cold
- 40 ○ ○ ○ Upper respiratory challenges

GROUP 3

- 41 ○ ○ ○ Eat when nervous
- 42 ○ ○ ○ Excessive appetite
- 43 ○ ○ ○ Hungry between meals
- 44 ○ ○ ○ Irritable before meals
- 45 ○ ○ ○ Get "shaky" if hungry
- 46 ○ ○ ○ Fatigue, eating relieves
- 47 ○ ○ ○ "Lightheaded" if meals delayed
- 48 ○ ○ ○ Heart palpitates if meals missed or delayed
- 49 ○ ○ ○ Fatigue in afternoons
- 50 ○ ○ ○ Overeating sweets upsets

- 51 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
- 52 ○ ○ ○ Crave candy or coffee in afternoons
- 53 ○ ○ ○ Moods of "blues" or melancholy
- 54 ○ ○ ○ Craving for sweets or snacks

GROUP 4

- 55 ○ ○ ○ Hands and feet go to sleep easily, numbness
- 56 ○ ○ ○ Sigh frequently, "air hunger"
- 57 ○ ○ ○ Aware of "breathing heavily"
- 58 ○ ○ ○ High altitude discomfort
- 59 ○ ○ ○ Opens windows in closed rooms
- 60 ○ ○ ○ Immune system challenges
- 61 ○ ○ ○ Afternoon "yawner"
- 62 ○ ○ ○ Get "drowsy" often
- 63 ○ ○ ○ Swollen ankles, worse at night
- 64 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
- 65 ○ ○ ○ Difficulty catching breath, especially during exercise
- 66 ○ ○ ○ Tightness or pressure in chest, worse on exertion
- 67 ○ ○ ○ Skin discolors easily after impact
- 68 ○ ○ ○ Tendency to anemia
- 69 ○ ○ ○ Noises in head, or "ringing in ears"
- 70 ○ ○ ○ Fatigue upon exertion

GROUP 5

- 71 ○ ○ ○ Dizziness
- 72 ○ ○ ○ Dry skin
- 73 ○ ○ ○ Burning feet
- 74 ○ ○ ○ Blurred vision
- 75 ○ ○ ○ Itching skin and feet
- 76 ○ ○ ○ Hair loss
- 77 ○ ○ ○ Occasional skin rashes
- 78 ○ ○ ○ Bitter, metallic taste in mouth in mornings
- 79 ○ ○ ○ Occasional constipation
- 80 ○ ○ ○ Worrier, feels insecure
- 81 ○ ○ ○ Nausea occasionally after eating
- 82 ○ ○ ○ Greasy foods upset
- 83 ○ ○ ○ Stools light colored
- 84 ○ ○ ○ Skin peels on foot soles
- 85 ○ ○ ○ Discomfort between shoulder blades
- 86 ○ ○ ○ Occasional laxative use
- 87 ○ ○ ○ Stools alternate from soft to watery
- 88 ○ ○ ○ Sneezing attacks
- 89 ○ ○ ○ Dreaming, nightmare type bad dreams
- 90 ○ ○ ○ Bad breath (halitosis)
- 91 ○ ○ ○ Milk products cause upset
- 92 ○ ○ ○ Sensitive to hot weather
- 93 ○ ○ ○ Burning or itching anus
- 94 ○ ○ ○ Crave sweets

GROUP 6

- 95 ○ ○ ○ Loss of taste for meat
- 96 ○ ○ ○ Lower bowel gas several hours after eating
- 97 ○ ○ ○ Burning stomach sensations, eating relieves
- 98 ○ ○ ○ Coated tongue
- 99 ○ ○ ○ Pass large amounts of foul-smelling gas
- 100 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 101 ○ ○ ○ Watery or loose stool
- 102 ○ ○ ○ Gas shortly after eating
- 103 ○ ○ ○ Stomach "bloating"

1 2 3 GROUP 7A

- 104 ○ ○ ○ Difficulty sleeping
- 105 ○ ○ ○ On edge
- 106 ○ ○ ○ Can't gain weight
- 107 ○ ○ ○ Intolerance to heat
- 108 ○ ○ ○ Highly emotional
- 109 ○ ○ ○ Flush easily
- 110 ○ ○ ○ Night sweats
- 111 ○ ○ ○ Thin, moist skin
- 112 ○ ○ ○ Inward trembling
- 113 ○ ○ ○ Heart races
- 114 ○ ○ ○ Increased appetite without weight gain
- 115 ○ ○ ○ Pulse fast at rest
- 116 ○ ○ ○ Eyelids and face twitch
- 117 ○ ○ ○ Irritable and restless
- 118 ○ ○ ○ Can't work under pressure

GROUP 7B

- 119 ○ ○ ○ Increase in weight
- 120 ○ ○ ○ Decrease in appetite
- 121 ○ ○ ○ Fatigue easily
- 122 ○ ○ ○ Ringing in ears
- 123 ○ ○ ○ Sleepy during day
- 124 ○ ○ ○ Sensitive to cold
- 125 ○ ○ ○ Dry or scaly skin
- 126 ○ ○ ○ Temporary constipation
- 127 ○ ○ ○ Mental sluggishness
- 128 ○ ○ ○ Hair coarse, falls out
- 129 ○ ○ ○ Tension in head upon arising wears off during day
- 130 ○ ○ ○ Slow pulse, below 65
- 131 ○ ○ ○ Changing urinary function
- 132 ○ ○ ○ Sounds appear diminished
- 133 ○ ○ ○ Reduced initiative

GROUP 7C

- 134 ○ ○ ○ Falling memory with age
- 135 ○ ○ ○ Increased sex drive
- 136 ○ ○ ○ Episodes of tension in head
- 137 ○ ○ ○ Decreased sugar tolerance

GROUP 7D

- 138 ○ ○ ○ Abnormal thirst
- 139 ○ ○ ○ Bloating of abdomen
- 140 ○ ○ ○ Weight gain around hips or waist
- 141 ○ ○ ○ Sex drive reduced or lacking
- 142 ○ ○ ○ Tendency for stomach issues
- 143 ○ ○ ○ Immune system challenges
- 144 ○ ○ ○ Menstrual disorders

GROUP 7E

- 145 ○ ○ ○ Dizziness
- 146 ○ ○ ○ Headaches
- 147 ○ ○ ○ Hot flashes
- 148 ○ ○ ○ Hair growth on face or body (female)
- 149 ○ ○ ○ Sugar in urine (not diabetes)
- 150 ○ ○ ○ Masculine tendencies (female)

GROUP 7F

- 151 ○ ○ ○ Weakness, dizziness
- 152 ○ ○ ○ Tired throughout day
- 153 ○ ○ ○ Nails weak, ridged
- 154 ○ ○ ○ Sensitive skin
- 155 ○ ○ ○ Stiff joints
- 156 ○ ○ ○ Perspiration increase
- 157 ○ ○ ○ Bowel discomfort
- 158 ○ ○ ○ Poor circulation
- 159 ○ ○ ○ Swollen ankles
- 160 ○ ○ ○ Crave salt
- 161 ○ ○ ○ Areas of skin darkening
- 162 ○ ○ ○ Upper respiratory sensitivity
- 163 ○ ○ ○ Tiredness
- 164 ○ ○ ○ Breathing challenges

1 2 3 GROUP 8

- 165 ○ ○ ○ Muscle weakness
- 166 ○ ○ ○ Lack of Stamina
- 167 ○ ○ ○ Drowsiness after eating
- 168 ○ ○ ○ Muscular soreness
- 169 ○ ○ ○ Heart races
- 170 ○ ○ ○ Hyperirritable
- 171 ○ ○ ○ Feeling of a band around your head
- 172 ○ ○ ○ Melancholia (feeling of sadness)
- 173 ○ ○ ○ Swelling of ankles
- 174 ○ ○ ○ Change in urinary function
- 175 ○ ○ ○ Tendency to consume sweets or carbohydrates
- 176 ○ ○ ○ Muscle spasms
- 177 ○ ○ ○ Blurred vision
- 178 ○ ○ ○ Involuntary muscle action
- 179 ○ ○ ○ Numbness
- 180 ○ ○ ○ Night sweats
- 181 ○ ○ ○ Rapid digestion
- 182 ○ ○ ○ Sensitivity to noise
- 183 ○ ○ ○ Redness of palms of hands and bottom of feet
- 184 ○ ○ ○ Visible veins on chest and abdomen
- 185 ○ ○ ○ Hemorrhoids
- 186 ○ ○ ○ Apprehension (feeling that something bad will happen)
- 187 ○ ○ ○ Nervousness causing loss of appetite
- 188 ○ ○ ○ Nervousness with indigestion
- 189 ○ ○ ○ Gastritis
- 190 ○ ○ ○ Forgetfulness
- 191 ○ ○ ○ Thinning hair

FEMALE ONLY

- 192 ○ ○ ○ Very easily fatigued
- 193 ○ ○ ○ Premenstrual tension
- 194 ○ ○ ○ Menses more painful than usual
- 195 ○ ○ ○ Depressed feelings before menstruation
- 196 ○ ○ ○ Painful breasts during menses
- 197 ○ ○ ○ Menstruate too frequently
- 198 ○ ○ ○ Hysterectomy / ovaries removed
- 199 ○ ○ ○ Menopausal hot flashes
- 200 ○ ○ ○ Menses scanty or missed
- 201 ○ ○ ○ Acne, worse at menses

MALE ONLY

- 202 ○ ○ ○ Less involved in exercise/social activities
- 203 ○ ○ ○ Difficult to postpone urination
- 204 ○ ○ ○ Weak urinary stream
- 205 ○ ○ ○ Feeling of "blues" or melancholy
- 206 ○ ○ ○ Feeling of incomplete bowel evacuation
- 207 ○ ○ ○ Lack of energy
- 208 ○ ○ ○ Muscles in arms and legs seem softer/smaller
- 209 ○ ○ ○ Tire too easily
- 210 ○ ○ ○ Avoids activity
- 211 ○ ○ ○ Leg nervousness at night
- 212 ○ ○ ○ Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.