Have you ever suffered from?	
	Alcoholism
	Allergies
	Anemia
	Arteriosclerosis
	Arthritis
	Abnormal Spinal Curvatures
	Back Pain
	Breast Lump
	Bronchitis
	Bruise Easily
	Cancer
	Chest Pain or Conditions
	Cold Extremities
	Constipation
	Depression
	Diabetes
	Digestion Problems
	Dizziness
	Ringing in the Ears
	Excessive Menstruation
	Eye Pain or Difficulty Seeing
	Fatigue
	Frequent Urination
	Headache
	Hemorrhoids
	High Blood Pressure
	Hot Flashes
	Irregular Heartbeat
	Irregular Cycle
	Kidney Infection
	Kidney Stones
	Loss of Memory
	Loss of Balance
	Loss of Smell
	Loss of Taste
	Neck Pain or Stiffness
	Nervousness
	Nosebleeds
	Pacemaker
	Polio
	Prostate Condition
	Sciatica
	Shortness of Breath
	Sinus Infection
	Sleep Problems or Insomnia
	STD
	Stroke
	Swelling of Ankles
	Swollen Joints
	Thyroid Condition
	Tuberculosis
	Ulcers
	Varicose Veins
	Other:

Please use the following letters to indicate the **TYPE** and **LOCATION** of the symptoms you currently are experiencing.

A = Ache
B = Burning
N = Numbness
O = Other
P = Pins and Needles
S = Stabbing