



Specializing in the treatment of: daily chronic pain, Fibromyalgia, Lyme Disease, grief and loss, cancer, food addiction, migraines, physical and emotional trauma, and sugar allergies

A fresh perspective for resolving daily chronic pain and illness.

170 West Patrick Street, Frederick, MD 21701

Phone: 301.228.FROG (301.228.3764)

Twofrogsh healingcenter@gmail.com

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent, the opportunity to agree or object, is not required in these instances:

- Treatment – Information obtained by your practitioner at the Two Frogs Healing Center will be entered into your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.
- Payment – Your record will be used to receive payment for services rendered by this practice. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, and / or practitioner's impressions, and procedures performed.
- Quality Monitoring – The staff in this office will use your health information to assess the care you received and compare your treatment outcomes to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

- Food and Drug Administration (FDA) – This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- Worker's Compensation – This office will release information to the extent authorized by law in matters of worker's compensation.
- Public Health – This office is required by law to disclose health information to public health and/ or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.
- Law Enforcement – (1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) in the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

It is the Two Frogs Healing Center's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, we will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- Business Associates – Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- Communications with Family – Using best judgment, a family member, close personal friend identified by you, a personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.
- Marketing and Fundraising – This office may send you information about treatment alternatives and other health-related benefits that you may find useful. We may also contact you to request your charitable support in order to keep patient fees reasonable and providing for continuing practitioner training and research. Persons contacting you may be the Two Frogs Healing Center employees other than your practitioner who will know only that you have been a patient but have no access to your medical records.



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Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Patient Health Information, describe how health information about you may be used and disclosed, and how you get access to your health information. Copies of this notice are given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you visit this practice. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of your practitioner, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities: This practice is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. The Two Frogs Healing Center of Frederick, Maryland reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, the Two Frogs Healing Center and your practitioner agree not to use or disclose your health information without your authorization.

To receive additional information or report a problem: you may contact your practitioner. If you believe your privacy rights have been violated, you have the right to file a complaint with the owner of the Two Frogs Healing Center, and /or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

I, _____, have received a copy of this Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these Notices.

Client / Patient Signature: _____ Date: _____

Signature of Witness: _____ Date: _____



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Voluntary: I hereby voluntarily consent to be treated with acupuncture, herbs, Craniosacral technique, and Sufi Healing.
I understand that treatment may involve the insertion of needles and/or the application of warmth or herbal formulas to my skin.
I understand that treatment may involve gentle hands-on contact with different areas of the body that relate to my conditions that I am coming for treatment.
I further understand that any questions I have regarding treatment and procedures will be answered to my satisfaction.

Possible Side Effects: I understand that the side effects from treatment, acupuncture, herbs, cupping, and vascular drainage may include temporary pain, slight bleeding, local bruising, or lightheadedness. According to the Law of Cure, it is possible that as healing occurs, certain symptoms may appear aggravated for a short time; this is considered a positive sign.

Medical Referral: I understand that if my condition worsens, a new ailment arises, or I do not improve within the time established by my acupuncturist at the beginning of treatment, I should consult a licensed physician.

Safety: I am aware that my practitioner uses only sterile, disposable needles or lancets which have never been used before and which are immediately disposed of in a Sharps container after use. My questions regarding safety have been answered and I know future questions would be welcome.

Returned Checks: I am aware that I will be charged an additional \$29 processing fee for each returned check.

Cancellation Policy: I understand that I may change or cancel an appointment at any time. If I cancel an appointment less than 24 hours before the agreed upon time, I understand that I will be charged the treatment fee. When I want to change or cancel an appointment, I will do so by phone at (301)228.FROG (301.228.3764).

Printed name of Client

Signature of Client

Date

Signature of Parent or Guardian

Date



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MEDICAL PROVIDER / MEDICATIONS & SUPPLEMENTS SHEET

Patient Name _____

Height _____ Weight _____ Age _____

Primary Physician Name _____

Physician Address _____

Physician Phone Number _____

(For information only, no contact will be made without permission)

Date of last appointment with regular physician: _____

Reason for that appointment _____

Please list all medications, vitamins, and / or food supplements you are currently taking.

Attach additional sheets if necessary:

Medications _____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

Vitamins _____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

_____ Dosage _____ Taking for: _____

Food Supplements _____



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OTHER MEDICAL PROVIDERS

Please list other medical providers you are seeing or have seen in the last 6 months. Include naturopaths, acupuncturists, chiropractors, physical therapists, nutritionists, massage therapists, and psychotherapists.

Practitioner Name / Specialty _____

(Example: Dr. John Doe / GI specialist)

Practitioner Address _____

Practitioner Phone Number _____

Date of last appointment: _____ Reason for that appointment _____

Practitioner Name / Specialty _____

Practitioner Address _____

Practitioner Phone Number _____

Date of last appointment: _____ Reason for that appointment _____

Practitioner Name / Specialty _____

Practitioner Address _____

Practitioner Phone Number _____

Date of last appointment: _____ Reason for that appointment _____

Practitioner Name / Specialty _____

Practitioner Address _____

Practitioner Phone Number _____

Date of last appointment: _____ Reason for that appointment _____



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DIET

List what you typically eat for breakfast, lunch, dinner, snacks, dessert, and alcohol consumption.

Breakfast _____

Lunch _____

Dinner _____

Dessert / Snacks _____

Alcohol / how often _____

Foods you crave _____

Foods you are allergic to: _____



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Please print the following data				Today's Date				Referred by																
Name				<input type="radio"/> Male		<input type="radio"/> Female		Race																
Address				<input type="radio"/> Married		<input type="radio"/> Separated		<input type="radio"/> Divorced		<input type="radio"/> Widowed		<input type="radio"/> Single												
Home phone				Education				years Elementary		years High School														
Work phone				Fax				years College or Business				Birthdate												
Cell phone				Occupation				Social Security or Medicare number:																
Email				Email address																				
Family history (blood or natural relatives, except spouse)																								
For each member of your family, please check the boxes for																								
1. Their present state of health																								
2. Any illness they have had																								
NAME		Good Health	Poor Health	Deceased	Age or age when deceased	If deceased, write in cause of death. Include fatal accidents and suicides.	Allergies or Asthma	Anemia	Blood clotting problems	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Genetic disease	Alcoholism	Kidney or Bladder trouble	Stomach or duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	High blood pressure	Heart trouble	Gout	Other	
Father:																								
Mother:																								
Brothers/																								
Sisters:																								
Spouse:																								
Child:																								
Child:																								
Child:																								
Paternal relatives (how many affected with ----->)																								
Maternal relatives (how many affected with ----->)																								
Your Health History, have you had =====>																								
Additional illnesses or problems																								
Mark an X in the box next to all that you have now or ever had.																								
<input type="checkbox"/> eye infections		<input type="checkbox"/> pneumonia		<input type="checkbox"/> neuralgia or neuritis		<input type="checkbox"/> scarlet fever		<input type="checkbox"/> mononeucleosis																
<input type="checkbox"/> thyroid disease		<input type="checkbox"/> pancreatitis		<input type="checkbox"/> tension/anxiety		<input type="checkbox"/> measles		<input type="checkbox"/> sexually transmitted disease																
<input type="checkbox"/> eczema		<input type="checkbox"/> liver disease		<input type="checkbox"/> depression		<input type="checkbox"/> mumps		<input type="checkbox"/> yellow jaundice																
<input type="checkbox"/> hives or rashes		<input type="checkbox"/> diverticulosis		<input type="checkbox"/> childhood hyperactivity		<input type="checkbox"/> polio		<input type="checkbox"/> tuberculosis																
<input type="checkbox"/> bronchitis		<input type="checkbox"/> hernia		<input type="checkbox"/> chicken pox		<input type="checkbox"/> rheumatic fever		<input type="checkbox"/> malaria																
<input type="checkbox"/> emphysema		<input type="checkbox"/> hemorrhoids		<input type="checkbox"/> German measles		<input type="checkbox"/> osteoporosis		<input type="checkbox"/>																
<input type="checkbox"/> hepatitis		<input type="checkbox"/> blood transfusion		<input type="checkbox"/> drug abuse		<input type="checkbox"/>		<input type="checkbox"/>																
Hospitalizations																								
If you have ever been hospitalized for any major medical illness, operations, or minor surgeries																								
Please list your most recent hospitalization first. Please indicate total number of hospitalizations.->																								
		Year	Reason for Hospitalization				Name of Hospital				City and State													
1st Hospitalization																								
2nd Hospitalization																								
3rd Hospitalization																								
4th Hospitalization																								
Tests and immunizations						Medicines																		
Mark an X in the box next to all that you have had.						Mark an X in the box next to all that you are taking, or that you are sensitive or allergic to.																		
Enter the year you were last given these tests or shots.						Taking																		
Year		Year		Year		Allergic to:		Taking		Allergic to:														
<input type="checkbox"/> _____ chest x-ray		<input type="checkbox"/> _____ tetanus shots		<input type="checkbox"/>		<input type="checkbox"/> antibiotics		<input type="checkbox"/>		<input type="checkbox"/> aspirin														
<input type="checkbox"/> _____ kidney x-ray		<input type="checkbox"/> _____ polio series		<input type="checkbox"/>		<input type="checkbox"/> penicillin		<input type="checkbox"/>		<input type="checkbox"/> diet pills														
<input type="checkbox"/> _____ G.I. series		<input type="checkbox"/> _____ typhoid series		<input type="checkbox"/>		<input type="checkbox"/> sulfa		<input type="checkbox"/>		<input type="checkbox"/> antacids														
<input type="checkbox"/> _____ colon x-ray		<input type="checkbox"/> _____ flu injections		<input type="checkbox"/>		<input type="checkbox"/> opiates/ codeine		<input type="checkbox"/>		<input type="checkbox"/> laxatives														
<input type="checkbox"/> _____ gallbladder x-ray		<input type="checkbox"/> _____ mumps shots		<input type="checkbox"/>		<input type="checkbox"/> diuretics/ water pills		<input type="checkbox"/>		<input type="checkbox"/> cold tablets														
<input type="checkbox"/> _____ electrocardiogram		<input type="checkbox"/> _____ measles shots		<input type="checkbox"/>		<input type="checkbox"/> sedatives		<input type="checkbox"/>		<input type="checkbox"/> anti-inflammatories														
<input type="checkbox"/> _____ TB test		<input type="checkbox"/> _____ hepatitis		<input type="checkbox"/>		<input type="checkbox"/> stimulants/ caffeine		<input type="checkbox"/>		<input type="checkbox"/>														
<input type="checkbox"/> _____ sigmoidoscopy		<input type="checkbox"/> _____ Lyme disease		<input type="checkbox"/>		<input type="checkbox"/> Demerol		<input type="checkbox"/>		<input type="checkbox"/>														
<input type="checkbox"/> _____ mammogram		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> blood pressure medicine		<input type="checkbox"/>		<input type="checkbox"/>														



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Please answer each question by writing an X on either the No or Yes line.			
When a question asks for specific information, write the answer on the line next to the question number.			
If you don't understand a question, or would like to discuss it, circle it's number.			
1. Do you have any skin problems?	No ___	___ Yes	1.
2. Does your skin itch or burn?	No ___	___ Yes	2.
3. Do you have trouble stopping even a small cut from bleeding?	No ___	___ Yes	3.
4. Do you bruise easily?	No ___	___ Yes	4.
5. Do you ever faint or feel faint?	No ___	___ Yes	5.
6. Is any part of your body always numb?	No ___	___ Yes	6.
7. Have you ever had seizures or convulsions?	No ___	___ Yes	7.
8. Has your handwriting changed lately?	No ___	___ Yes	8.
9. Do you have a tendency to shake or tremble?	No ___	___ Yes	9.
10. Are you nervous around strangers?	No ___	___ Yes	10.
11. Do you find it hard to make decisions?	No ___	___ Yes	11.
12. Do you find it hard to concentrate or remember?	No ___	___ Yes	12.
13. Do you usually feel lonely or depressed?	No ___	___ Yes	13.
14. Do you often cry?	No ___	___ Yes	14.
15. Would you say you have a hopeless outlook?	No ___	___ Yes	15.
16. Do you have difficulty relaxing	No ___	___ Yes	16.
17. Do you have a tendency to worry alot?	No ___	___ Yes	17.
18. Are you troubled by frightening dreams or thoughts?	No ___	___ Yes	18.
19. Do you have a tendency to be shy or sensitive?	No ___	___ Yes	19.
20. Do you have a strong dislike for criticism?	No ___	___ Yes	20.
21. Do you lose your temper often?	No ___	___ Yes	21.
22. Do little things often annoy you?	No ___	___ Yes	22.
23. Are you disturbed by any work or family problems?	No ___	___ Yes	23.
24. Are you having any sexual difficulties?	No ___	___ Yes	24.
25. Have you ever considered committing suicide?	No ___	___ Yes	25.
26. Have you ever desired or sought psychiatric help?	No ___	___ Yes	26.
27. Have you gained or lost more than 10 pounds in the last 6 months?	No ___	___ Yes	27.
28. Do you have a tendency to be too hot or too cold?	No ___	___ Yes	28.
29. Have you lost your interest in eating lately?	No ___	___ Yes	29.
30. Do you always seem to be hungry?	No ___	___ Yes	30.
31. Are you more thirsty than usual lately?	No ___	___ Yes	31.
32. Are there any swellings in your armpits or groin?	No ___	___ Yes	32.
33. Do you seem to feel exhausted or fatigued most of the time?	No ___	___ Yes	33.
34. Do you either have difficulty falling asleep or staying asleep?	No ___	___ Yes	34.
35. Do you exercise more than three times a week?	Yes ___	___ No	35.
36. How much do you smoke per day?		___ Cigarettes ___ Cigars/Pipes	36.
		___ Don't smoke	



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37. Do you take two or more alcoholic drinks per day?	No ___	___ Yes	37.
38. Do you drink more than six cups/glasses of coffee, tea, or cola soda per day?	No ___	___ Yes	38.
39. Are you a regular user of sleeping pills, marijuana, tranquilizers, pain killers, etc.?	No ___	___ Yes	39.
40. Have you ever used heroin, cocaine, LSD, PCP, etc?	No ___	___ Yes	40.
41. Do you drive a motor vehicle more than 25,000 miles per year?	No ___	___ Yes	41.
42. How often do you use seat belts when riding in cars?		___ Never ___ Sometimes	42.
	___ Always		
43. List any country outside the United States you have visited in the past six months			43.
44. Are you troubled by heartburn?	No ___	___ Yes	44.
45. Do you feel bloated after eating?	No ___	___ Yes	45.
46. Are you troubled by belching?	No ___	___ Yes	46.
47. Do you suffer discomfort in the pit of your stomach?	No ___	___ Yes	47.
48. Do you easily become nauseated (feel like vomiting)?	No ___	___ Yes	48.
49. Have you ever vomited blood?	No ___	___ Yes	49.
50. Is it difficult or painful for you to swallow?	No ___	___ Yes	50.
51. Are you constipated more than twice a month?	No ___	___ Yes	51.
52. Are your bowel movements ever loose for more than one day?	No ___	___ Yes	52.
53. Are your bowel movements ever black or bloody?	No ___	___ Yes	53.
54. Do you suffer pains when you move your bowels?	No ___	___ Yes	54.
55. Have you had any bleeding from your rectum?	No ___	___ Yes	55.
56. Do you frequently get up at night to urinate?	No ___	___ Yes	56.
57. Do you urinate more than five or six times a day?	No ___	___ Yes	57.
58. Do you wet your pants or wet your bed?	No ___	___ Yes	58.
59. Have you ever had burning or pains when you urinate?	No ___	___ Yes	59.
60. Has your urine ever been brown, black, or bloody?	No ___	___ Yes	60.
61. Do you have any difficulty starting your urine flow?	No ___	___ Yes	61.
62. Do you have a constant feeling that you have to urinate?	No ___	___ Yes	62.
*** FOR MEN ONLY			
63. Is your urine stream very weak and slow?	No ___	___ Yes	63.
64. Has a doctor ever told you that you have prostate trouble?	No ___	___ Yes	64.
65. Have you had any burning or discharge from your penis?	No ___	___ Yes	65.
66. Are there any swellings or lumps on your testicles?	No ___	___ Yes	66.
67. Do your testicles get painful?	No ___	___ Yes	67.
*** FOR WOMEN ONLY			
68. What was the date of your last menstrual period?		___ / ___ / ___	68.
69. Are you past menopause or have you had a hysterectomy?	No ___	___ Yes	69.
70. If yes: Have you noticed any vaginal bleeding since? (Please skip to question 74)	No ___	___ Yes	70.
71. Was your last menstrual period normal?	Yes ___	___ No	71.
72. Do you have heavy bleeding with your periods?	No ___	___ Yes	72.



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73. Have you had bleeding between your periods?	No___	___Yes	73.
74. Do you ever have bleeding after intercourse?	No___	___Yes	74.
75. Have you had any recent vaginal itching or discharge?	No___	___Yes	75.
76. Do you examine your breasts at least once a month?	Yes___	___No	76.
77. Have you ever noticed any lumps or pain in your breasts?	No___	___Yes	77.
78. Have you had complications with any type of birth control?	No___	___Yes	78.
79. Write in the month and year of your last Pap test		___/___/___	79.
Print the following information in the spaces at the right >>>>			
80. Number of pregnancies		_____	80.
81. Number of children born alive		_____	81.
82. Number of premature births		_____	82.
83. Number of miscarriages		_____	83.
84. Number of stillbirths		_____	84.
85. Have you ever had an abortion?	No___	___Yes	85.
*** Questions 86-134 are for both MEN and WOMEN			
86. Are you troubled with stiff or painful muscles or joints?	No___	___Yes	86.
87. Are your joints ever swollen?	No___	___Yes	87.
88. Are you troubled by pains in the back or shoulder?	No___	___Yes	88.
89. Are your feet often painful?	No___	___Yes	89.
90. Are you handicapped or disabled in any way?	No___	___Yes	90.
91. Do you have headaches more than once a week?	No___	___Yes	91.
92. Does twisting your neck quickly cause pain?	No___	___Yes	92.
93. Have you ever had lumps or swelling in your neck?	No___	___Yes	93.
94. Do you wear glasses or contacts?	No___	___Yes	94.
95. Does your eyesight ever blur?	No___	___Yes	95.
96. Is your eyesight getting worse?	No___	___Yes	96.
97. Do you ever see double?	No___	___Yes	97.
98. Do you ever see colored halos around lights?	No___	___Yes	98.
99. Do you ever have pains or itching in or around your eyes?	No___	___Yes	99.
100. Do your eyes blink or water most of the time?	No___	___Yes	100.
101. Have you ever had any trouble with your eyes in the last two years?	No___	___Yes	101.
102. Do you have difficulty hearing?	No___	___Yes	102.
103. Have you had any earaches lately?	No___	___Yes	103.
104. Have you been troubled by running ears lately?	No___	___Yes	104.
105. Do you have a repeated buzzing or other noises in your ears?	No___	___Yes	105.
106. Do you get motion sickness riding in a car or plane?	No___	___Yes	106.
107. Do you have any problems with your teeth?	No___	___Yes	107.
108. Do you have any sore swellings on your gums or jaws?	No___	___Yes	108.
109. Is your tongue sore or sensitive?	No___	___Yes	109.
110. Has your sense of taste changed lately?	No___	___Yes	110.
111. Is your nose stuffed up when you don't have a cold?	No___	___Yes	111.
112. Does your nose run when you don't have a cold?	No___	___Yes	112.
113. Do you ever have sneezing spells?	No___	___Yes	113.
114. Do you ever have head colds two or more months in a row?	No___	___Yes	114.
115. Does your nose ever bleed for no reason at all?	No___	___Yes	115.
116. Is your throat ever sore when you don't have a cold?	No___	___Yes	116.

