Biotech Natural Medicine

Dr. Tim McCullough

Albuquerque
4801 Lang Ave NE UNIT 110,
Albuquerque, NM 87109
Phone: 281-996-7701

DC, DABCI, APC

CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need help, please ask the receptionist.

Patient Data: Date _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Work Phone _____

E-Mail _____ Who referred you? _____

Is your visit due to an accident? Yes No

Age _____ Birth Date _____ Marital Status _____ Number of Children _____

Occupation _____ Employed _____ SS# _____

Name of Nearest Relative _____ Phone Number _____

Name of Wife or Husband _____ Phone Number _____

Occupation _____ Employed _____ SS# _____

Present Complaint:

Briefly Describe Symptoms _____

_____

List Other Doctor/s Seen For This Condition _____

Medical History (If any of the following are relevant to your medical history, ☑ please the accompanying box.)

[ ] Cancer	[ ] Muscular Dystrophy	[ ] Rheumatic Fever
[ ] Polio	[ ] Multiple Sclerosis	[ ] Scarlet Fever
[ ] Tuberculosis	[ ] Convulsions	[ ] Nervousness
[ ] High Blood Pressure	[ ] Epilepsy	[ ] Asthma
[ ] Heart Trouble	[ ] Concussion	[ ] Digestive Disorder
[ ] Diabetes	[ ] Dizziness	[ ] Sinus Trouble
[ ] Hepatitis	[ ] Arthritis	[ ] Backaches
[ ] German Measles	[ ] Neuritis	[ ] Numbness
[ ] Venereal Disease	[ ] Rheumatism	[ ] Anemia

Describe the operation you've had: _____ When? _____

Have you been treated by a physician for any health condition in the last year? ☑ Yes ☑ No _____

Describe Condition _____ Date of last physical exam _____

Are you allergic to any medication? [ ] Yes [ ] No What Kind? _____

Are you taking any medications? [ ] Yes [ ] No What Kind? _____

Are You Pregnant Yes No Date of Last Menstrual Period _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection fro the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. however, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse's Or Guardian's Signature _____ Date _____

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Patient Acknowledgement of Disclosure of Protected Health Information

Patient's Name: _____ Date: _____

I, the undersigned, do agree the above referenced office may contact me regarding any information necessary in the operation of the clinic. This includes, but is not limited to, patient follow-ups, appointments, medical reports and information that the doctor or staff deems necessary in providing healthcare services to you.

In accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security, Section 164.520 (c)(2)(i) and Section 164.520 (c)(2)(ii), I have received written notice of this office's privacy compliance.

My signature on this letter is written acknowledgement of notification of receipt.

_____ _____

Signature of patient (or guardian) Date of signature

*A copy of this notification is given to you (upon request) and the original will be kept in your medical file.

Acknowledgement of this signature is verified and witnessed by:

_____ _____

Privacy Officer Date of signature

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AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient at this clinic, hereby authorize Dr. McCullough and whomever he may designate as his assistant, to administer examinations and treatment as is necessary, and to perform therapy and adjustments and such additional therapy or procedures as are considered therapeutically necessary during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment. The reasons that the above named treatment are considered necessary, the advantages and possible complications, if any, as well as possible alternative modes of treatment which are explained to me by Dr. McCullough, and I certify that no guarantee or assurance has been made as to the results that may be obtained. I also understand that any supplements that are recommended for me are an aid in supplying the body those nutrients that Dr. McCullough has determined may be of benefit to me.

DATE: _____

SIGNED: _____

WITNESS: _____

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MEDICAL HISTORY

Thank You for taking your time to fill out this Medical History Form.
We want to make sure you are receiving the best possible care by understanding your Medical History. This Medical History Form has been created with the intent to honor all current laws while meeting your needs and the doctor's requirements for establishing accurate medical records. This may seem like a long form, however, the most important thing to us is your health and your Health History provides us important information to help you with the best treatment plans, protocols, and suggestions.
Thank You for your time and interest in Biotech Natural Medicine Clinic with Dr. Tim McCullough, D.C.,D.A.B.C.I.

1). Personal Information:

PLEASE PRINT: TODAY'S DATE:_____/_____/_____

NAME: (Last)_____(First)_____(Middle)_____

EMAIL: Personal_____Wk: _____

Would you like to be on our mailing list and receive our free Newsletter?

No __ / YES __, If Yes, How would you like us to contact you: Email ○ Standard Mail ○

2). Make a Concise List Of Specific Problems / Symptoms You Want To Discuss During Your Appointment Today:

List your symptoms, when they started and if you think you know what may be contributing to them:

3). Have You Been Diagnosed with an Illness Recently? NO ○ / YES ○ *Please list.*

Who gave you this diagnosis as indicated above? NAME:_____

Phone (_____)_____Address: _____

City:_____State:_____Approximate Date of Diagnosis:_____/_____/_____

4). Have you been hospitalized for the diagnosis listed in question 2 or 3 above ? NO ○ / YES ○ *If Yes, provide additional information:*

Hospital/Clinic:_____City:_____State:_____Approximate Date(s)_____/_____/_____

5). Are You Scheduled For Any Treatments, Surgeries or Hospitalization?

NO ○ / YES ○ Reason: _____

Hospital/Clinic:_____City:_____State:_____Approximate Date(s)_____/_____/_____

6). Are You Currently On Any Perscription Medications, Vitamins or Nutritional and/or Herbal Supplements?

NO ○ / YES ○ **Please list as many as possible, dosage, how long you have been taking them and their purpose. It is important for Dr. McCullough to review your medications, vitamins and/or supplements.(Provide Info Below):**

_____

_____

_____

_____

_____

_____

_____

_____

7). What significant changes have occurred in your life recently than may have affect and your health, stress level, diet, sleep, and energy?

8). **NUTRITION HISTORY:** ***Please √ Check the Column "or" Make a Brief Comment that Best Applies for the Following:***

DO YOU EAT:	√ NO	√ YES	Occasionally	Describe Details	Special Diet	Other / Notes:
BREAKFAST						
LUNCH						
DINNER						
Snack Frequently						
VEGITARIAN						
MEAT						
FISH						
POULTRY						
*Low Fat Diet				Fat inTake ( )	Grams per Day	
CAFFEINE				Amt per Day: Amt per Week:		
ALCOHOL				Amt per Day: Amt per Wk:		
TOBACCO				Amt per Day: Amt per Wk:		

****ADDITIONAL COMMENTS REGARDING YOUR PERSONAL NUTRITION:** *(Please use the bottom of page #8 if needed for complete answer).*

9). FAMILY HISTORY: *(Please use bottom of page #8 if needed for complete answer).*

FAMILY MEMBER: PRESENT AGE or AGE at DEATH: IF LIVING, Health Condition (Good, Fair, Poor) **IF DECEASED, Cause**

FATHER: _____

MOTHER: _____

BROTHER(s): _____

SISTER(s): _____

CHILDREN: _____

Spouse: _____

Significant Other: _____

Other Relations that could influence on your health and wellbeing: _____

HAS ANY MEMBER OF YOUR FAMILY HAD THESE PROBLEMS? Please √ Check Column or Make Brief Comment That Applies for the Following:

"FAMILY" HEALTH :	√ NO	√ YES	What Famliy Member? Notes:
Anemia			
Arthritis			
Asthma			
Bleeding Tendency			
Breast Cancer			
Cancer			
Chronic Fatigue			
Chronic Lung Disease			
Colon Disease			
Diabetes			
Gout			
Heart Disease			

"FAMILY" HEALTH :	√ NO	√ YES	What Famliy Member? Notes:
High Blood Pressure			
HIV / AIDS			
Kidney Disease			
Leukemia			
Mental Illness			
Migraines			
Obesity			
Seizures			
Severe Allergies			
Thyroid Disease			
Tuberculosis			
*Other (Specify)			

****ADDITIONAL COMMENTS REGARDING YOUR FAMILY HEALTH PROBLEMS:** *(Use bottom of page #8 if needed for complete answer).*

_____

10). "YOUR" PAST MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING:

"YOUR" HEALTH:	√ NO	√ YES	Other / Notes & Dates:
Allergies			
Anemia			
Arthritis			
Asthma			
Back Problems			
Bladder Infection			
Bleeding Tendency			
Blood Transfusions			
Breast Cancer			
Bronchitis			
Cancer			
Chronic Fatigue			
Chronic Infections			
Chronic Lung Disease			
Chronic Sinusitis			
Colon Disease			
Diabetes			
Diphtheria			
Endometriosis			
Fibrocystic Breasts			
Gout			
Heart Disease			

"YOUR" HEALTH:	√ NO	√ YES	Other / Notes & Dates:
*Hepatitis (Yellow Jaundice)			*Circle Type: A B C
High Blood Pressure			
**HIV			**Circle if Opportunistic
Hives			
Hypoglycemia			
Infectious MONO			
Kidney Disease			
Measles			
Meningitis			
Mental Illness			
Migraines			
Mumps			
Opportunistic Infection			
Pleurisy			
Pneumonia			
Polio			
Rheumatic Fever			
Scarlet Fever			
TB "or" (Exposure To			
Tuberculosis			
Ulcer			
*Other (Specify)			

11). Have You EVER had a Sexually Transmitted Infection? *Circle Answer:* NO / YES "or" Venereal Disease: NO / YES

If YES to having Infection or Disease, Please Specify:

12). **OPERATIONS, INJURIES & PROCEDURES:** HAVE YOU EVER HAD ANY OF THE FOLLOWING *(List, Describe and Date)*

OPERATIONS:	√ NO	√ YES	Other / Notes:	Dates:
Appendix				
Breast				
Gall Bladder				
Heart				
Hemorrhoids				
Hernia				
Laminectomy				
Laparoscopy				
Prostate				
Stomach				
Thyroid				
Tonsils				
Uterus *and/or* Ovaries				
Plastic Surgery			Why:	
" "			Where:	
" "			Elective, Yes / No	
*Other (Specify)				

INJURIES:	√ NO	√ YES	Other / Notes:	Dates:
Abdomen				
Arms				
Back				
Broken Bones				
Chest				
Feet				
Hands				
Head				
Legs				
*Other (Specify)				

PROCEDURES:	√ NO	√ YES	Other / Notes:	Dates:
Colonoscopy				
Hormone Therapy				
MRI				
XRAY				
LifeScan				
*Other (Specify)				

***ADDITIONAL COMMENTS REGARDING YOUR OPERATIONS & INJURIES:** *(Please use bottom of page #8 if needed for complete answer)*

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13). **ALLERGIES & IMMUNIZATIONS, HAVE YOU EVER HAD ANY OF THE FOLLOWING:**

ALLERGIES:	√ NO	√ YES	Other / Notes:
ALLERGY TESTING			
ALLERGIC To:			
Cosmetics			
Foods (Specify)			
Environment (Specify)			
ALLERGIC to DRUGS			
Penicillin			
Sulfur			
Tetanus			
*Other (Specify)			

IMMUNIZATION:	√ NO	√ YES	Other / Notes:	Dates:
Hepatitis				
Polio				
Smallpox				
Tetanus				
Flu				
*Other (Specify)				

***ADDITIONAL COMMENTS REGARDING YOUR ALLERGIES & IMMUNIZATIONS:** *(Use bottom of page #8 if needed for complete answer)*

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14). **REVIEW of SYSTEMS, HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CHECK APPROPRIATE BOX for EACH ITEM BELOW)** *(Please use bottom of page # 8 if needed for complete answer).*

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
GENERAL:				
Tire Easily or Weakness				
Sudden Weight Change				
Weight Chg Up or Down?				How Much Wt?
Night Sweats				
Persistent Fever				
Sensitivity to Heat				
Sensitivity to Cold				
*Other (Specify)				

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
EYES:				
Difficulty Seeing				
Eye Pain				
Double Vision				
Wear Glasses/Contacts				
Cataracts				
*Other (Specify)				

(14. Continued): ***REVIEW of SYSTEMS, HAVE YOU EVER HAD ANY OF THE FOLLOWING:***
(CHECK APPROPRIATE BOX for EACH ITEM BELOW) *(Use bottom of page #8 if needed for complete answer)*

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
NERVOUS SYSTEM:				
Headaches				
Dizziness				
Fainting				
Seizures				
Anxiety				
Depression				
Memory Loss				
Difficulty Sleeping				
Numbness & Tingling				
Loss of Strength				
Paralysis				
Changes Sense of Touch				
*Other (Specify)				
RESPIRATORY :				
Persistent Cough				
Chronic Sputum (phlegm)				
Cough Up Blood				
Shortness of Breath				
Wheezing				
Pain Breathing				
Difficult Breath LyingDown				
Bluish Fingers or Lips				
*Other (Specify)				
CARDIO-VASCULAR:				
Chest Pain or Discomfort				
Heart Palpitations				
High Blood Pressure				
Stroke				
Varicose Veins				
High Cholesterol				
Heart Murmur				
*Other (Specify)				
ENDOCRINE:				
Diabetes				
Adrenal Problems				
Cortisone TX Longterm				
Thyroid Problems				
Pituitary Problems				
Polycystic Ovary Disease				
Hormonal Imbalance				
PMS				
*Other (Specify)				
BREAST:				
Breast Lump				
Nipple Discharge				
Fibrocystic Changes				
Breast Implants				
Breast Cancer				
*Other (Specify)				

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
EARS:				
Loss of Hearing				
Ringing in your Ears				
Discharge from Ears				
Itching Ears				
*Other (Specify)				
NOSE:				
Loss of Smell				
Sinus Drainage				
Nose Bleeds				
Deviated Septum				
*Other (Specify)				
THROAT:				
Soreness				
Difficulty Swallowing				
Post Nasal Drainage				
Chronic Hoarseness				
*Other (Specify)				
MOUTH:				
Bad Breath				
Dental Problems				
Silver Dental Fillings				
Sore Gums				
Soreness of Tongue				
Canker Sores				
Cold Sores				
*Other (Specify)				
SKIN:				
Acne				
Eczema				
Psoriasis				
Rashes				
Changes in Nails				
Hair Loss				
*Other (Specify)				
MUSCLES & JOINTS:				
Muscle Pain				
Muscle Weakness				
Muscle Cramps				
Pain in Joints				
Swollen Joints				
Deformity in Joints				
Stiffness				
*Other (Specify)				

(14. Continued): REVIEW of SYSTEMS, HAVE YOU EVER HAD ANY OF THE FOLLOWING:
(CHECK APPROPRIATE BOX for EACH ITEM BELOW) *(Use bottom of page #8 if needed for complete answer)*

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
GASTROINTESTINAL:				
Change in Appetite				
Difficulty Swallowing				
Heart Burn (Indigestion)				
Belching				
Flatulence (excess gas)				
Abdominal Bloating				
Nausea				
Vomiting				
Vomiting Blood				
Constipation				
Diarrhea				
Hemorrhoids				
Rectal Bleeding				
Tarry Stools				
Need for Laxatives				
Gallstones				
Abdominal Pain				
*OTHER (SPECIFY):				

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
EYES:				
Difficulty Seeing				
Eye Pain				
Double Vision				
Wear Glasses/Contacts				
Cataracts				
*OTHER (SPECIFY):				
GENITOURINARY:				
Urination (Info):				
Urination Pain/Burning				
Increase Frequency (day)				
More Frequency (night)				
Urgency to Urinate				
Incontinence: (Unable to Hold Urine)				
*OTHER (SPECIFY):				

******ADDITIONAL COMMENTS REGARDING REVIEW OF YOUR SYSTEMS:*** *(Use bottom of page #8 if needed for complete answer)*

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15). What Healing Modalities Have You Tried Before? What Alternative Healing Modalities Are You Interested In Knowing About?

Please √ check the column OR make a brief comment that best applies for the following:

HEALING MODALITIES:	√ CURRENT	√ OFTEN	√ SELDOM	√ Not Experienced	√ Interested	Other / Notes:
Acupuncture						
Aromatherapy						
Chelation Therapies						
Chiropractic						
Colonics						
Cranial-Sacral Therapy						
Massage						
Neural Therapy						
OMT, Osteopathic Manipulation						
Psychotherapy						
Reiki						
Yoga						
Other: (Specify)						
Other: (Specify)						
Other: (Specify)						
Other: (Specify)						

******ADDITIONAL COMMENTS REGARDING YOUR MEDICAL HISTORY, ALTERNATIVE HEALING MODALITIES & HEALTHCARE NEEDS:***
(Use bottom of page #8 if needed for complete answer)

16). Have you had any Tooth Aches, Dental Problems or Dental Work Done Lately?

NO ○ / YES ○ If Yes, Specify: Dates: / / Dentist Name: Phone:
Specify Type of Dental Problem or Work Done:

17). Are you interested in a Custom Wellness Plan to help "Awaken Your Health" in your life?

Circle Areas of interest for you: Nutrition Analysis; Vitamins & Supplements; Diet Plan for Weight Loss or Weight Gain; Healthy Heart; Healthy Aging; Improved Immune System; Improved Sleep; Improved Energy; Diagnostics for Certain Condition or Wellness Profile; Other: *(List or Describe Details)*

18). OB / GYN – WOMEN ONLY: Date of Last PAP Test: / / Details Regarding Last PAP Test:

Normal ○ / **Abnormal** ○ *Details:* **Type of PAP Test**: (*Circle Type if Known*):

Conventional PAP Smear *(Collection and "smearing" cervical cells on slide, collected cells sent to lab in a vial for testing)*

Liquid-Based Pap Tests *(ThinPrep® & SurePath®) (Cervical cells placed in jar of liquid fixative for rinsing & transport to lab)*

PAP Lab-Testing Done For: (*Circle if Known*): Detection of Cervical Cancer, Pre-Cancerous Lesions, Atypical Cells, HPV,DNA Testing, Gonorrhoeae, Chlamydia, Genital Warts (Condylomata), Other:

Started Menstruating at Age: Date of Last Cycle: / / Frequency of Periods:

Average # of Days of Menstrual Cycles Days **Duration of Normal Cycle:** Days **Flow:** Light ○ / Normal ○ / Heavy ○
Additional Info Menstrual Cycle:

Pain with Cycle: NO ○ / YES ○ If Yes, Specify:

Do You Clot with Your Menstrual Cycles: NO ○ / YES ○ If Yes, Specify:

Endometriosis: NO ○ / YES ○ If Yes, Specify:

Number of Miscarriages: **Number of Births:** Vaginal ○ C-Section ○ **Did You Breast Feed?** NO ○ YES ○

Specify Any Important Birthing Details:

Date of Last Mammogram: / / Results of Mammogram:

Have You Experienced Thermography: NO ○ / YES ○ If Yes, Specify Dates, Type, Where and Results of Thermography:

Monthly Breast Self-Exams? NO ○ / YES ○ Occasionally ○ Specify:

Are You Sexually Active? NO ○ / YES ○ Occasionally ○ Specify:

Experience Pain w/ Intercourse? NO ○ / YES ○ Occasionally ○ Specify:

Method of Contraception:

Are You Satisfied with this method? NO ○ / YES ○

Experience Night Sweats? NO ○ / YES ○ Occasionally ○ Specify:

Experience Hot Flashes? NO ○ / YES ○ Occasionally ○ Specify:

Experience Hot/Cold Intolerance? NO ○ / YES ○ Occasionally ○ Specify:

19). OB / GYN – HEALTH HISTORY WOMEN ONLY: Note: Some questions listed in chart below may have been previously asked on this Medical History Form. Please answer ALL questions on this page as part of your OB/GYN Medical History in order to provide Dr. McCullough the most complete review in this category for WOMEN'S HEALTH.

(WOMEN'S HEALTH CHECK APPROPRIATE BOX for EACH ITEM BELOW)

OB/GYN: Women Only	√ NO	√ Current	√ Previous	Dates & Notes:
Fever				
Weight Gain / Loss				
Change in Appetite				
Fatigue				
Mood Swings				
Depression				
Sleep Disturbances				
Flatulence (excess gas)				
Abdominal Bloating				
Abdominal Pain				
Nausea				
Vomiting				
Vomiting Blood				
Constipation				
Need for Laxatives				
Diarrhea				
Hemorrhoids				
Rectal Bleeding				
Tarry Stools				
Bloody Stools				
Gallstones				
Ear Ache				
Ringing in Ear				
Vision Changes				
Dry Eyes				
Red, Itchy Eyes				
Eye Disease/Disorder				
Sinus Pain/Headache				
Headaches				

OB/GYN: Women Only	√ NO	√ Current	√ Previous	Dates & Notes:
Chest Pain				
Rapid Heart Beat				
Persistent Cough				
Wheezing				
Shortness of Breath				
Hard to Breath (Lying Dwn)				
Mouth Sores				
Persistent Sore Throat				
Swollen Lymph Nodes				
Skin Rash				
Hives, Blisters				
Dizziness				
Numbness				
Seizures				
Incontinence: (Unable to Hold Urine)				
Urination Pain/Burning				
Increase Frequency (day)				
More Frequency (night)				
Urgency to Urinate				
Joint or Muscle Pain				
Muscle Weakness				
Swollen Hands or Feet				
Easy Bruising				
Easy Bleeding				
Painful Breasts				
Breast Lumps				
Nipple Discharge				
*OTHER (SPECIFY):				

20). OB / GYN – MENOPAUSAL WOMEN ONLY:

Do You Use Hormones? No ○ / Yes ○ Occasionally ○ If So, What Type? Specify: _____

Any Vaginal Bleeding? No ○ / Yes ○ Occasionally ○ If So, Specify: _____

When Did Your Menstrual Periods Stop? Specify: _____

Have You Had A Colonoscopy? No ○ / Yes ○ If Yes, Dates & Specify: _____

Have You Had A Bone Density Test? No ○ / Yes ○ If Yes, Dates & Specify: _____

What Other Tests, Exams or Conditions Relate To Your Menopausal Health? Specify: _____

Use The Space Below If Needed To Complete Any Answers From Pages 1-8 of This Medical History Questionnaire: Ask for Additional Paper if Needed!

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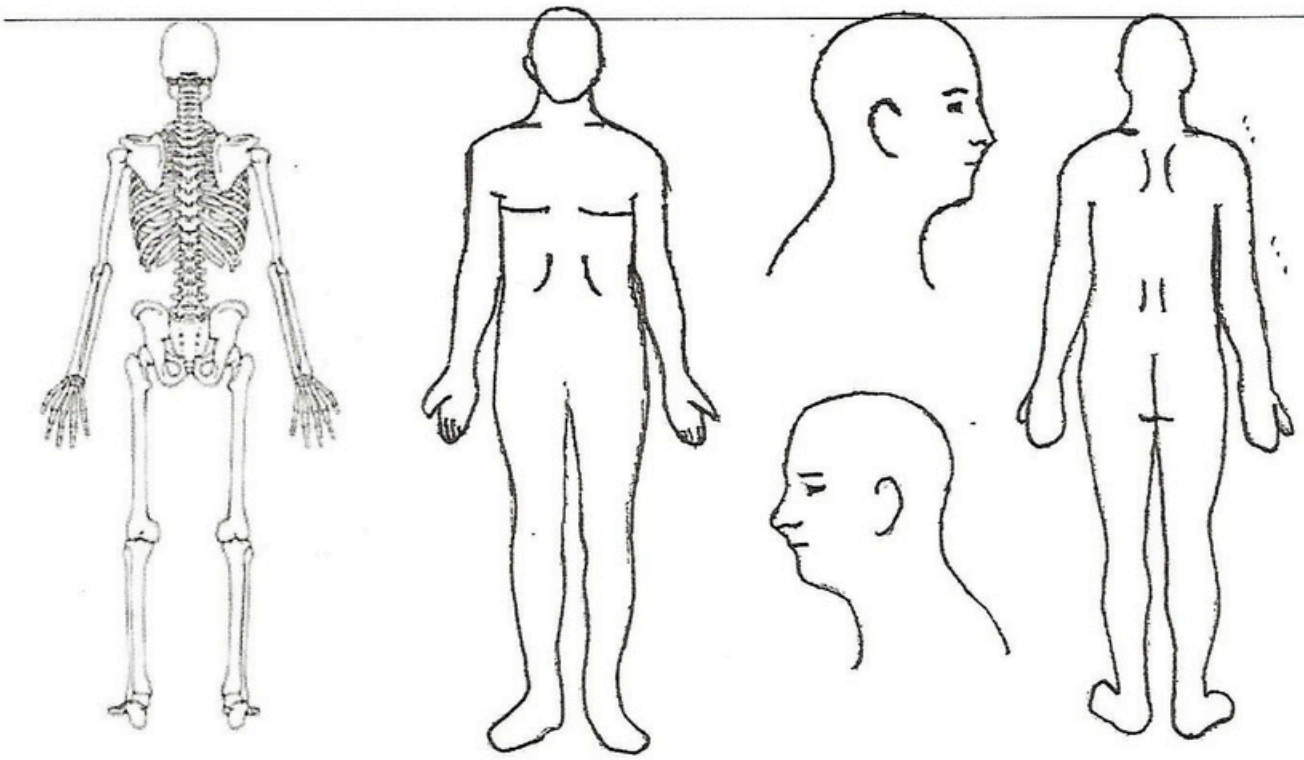
NEURO THERAPY CHART

Instructions: Please mark with number 1-14 on the body chart any scars, burns, infections sites, or lesion that left a mark on your body. Start with number 1 and mark the first lesion then list continue to the skeleton and mark any fractures, surgeries or biopsies with the corresponding numbered blanks with the date and reason. If you need more than 14 blanks ask for another sheet.

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.
13.	14.

Have you had your tonsils/adenoids removed? ☐ No ☐ Yes Date: _____
Are you taking blood pressure medication? ☐ No ☐ Yes Date: _____
Have you been treated for heart disease? ☐ No ☐ Yes Date: _____



List any allergies to Procaine, Lidocaine or any drugs or substances._____

Patient's Name _____ Age _____ Date _____

Please use the numbered teeth below to indicate on the other side which teeth have a dental intervention. **ALSO**, please use the **KEY** to mark appropriately on the dental chart, and answer upper/lower, if appropriate.

Key

Pulled teeth ×

Cavities filled ●

Crowns ■

Bridge □

Root canals o

Dentures?

_____ _____

Upper Lower

Braces?

_____ _____

Upper Lower

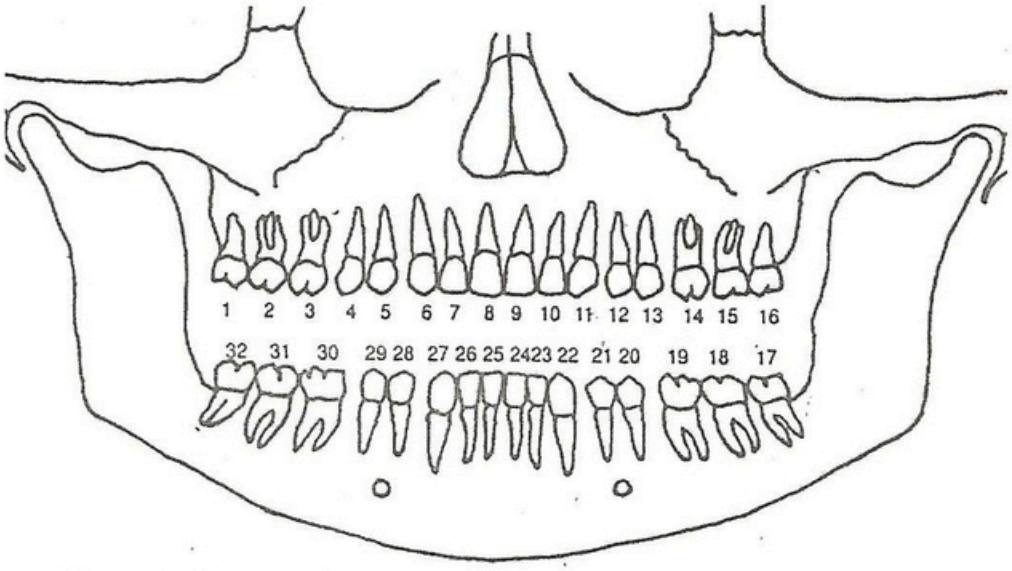
Retainer or Night Guard?

_____ _____

Upper Lower

Dental Chart

R L



Write your chief complaints(s) below and indicate the approximate age of onset.

Health Complaint	Age	Health Complaint	Age
1.		4.	
2.		5.	
3.		6.	

E. Finally, mark with an "X" where you have pain or dysfunction.