HEALTH SCREENING QUESTIONNAIRE

Please check if you have any of the following:

Patient Name: _____ Date: _____

Insurance:_____

Phone #: _____ Email:_____

Office/Referring Practitioner and Phone #: _____

- **Tired or Heavy Legs**
- **Restless Legs**
- **Leg Cramps or Charley Horses**
- **Leg Swelling**
- **Back Pain**
- **Hip Pain**
- **Knee Pain**
- **Leg or Calf Pain**
- **Foot Pain**
- **Sciatica**
- **Varicose or Spider Veins**

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