

NEW PATIENT PACKET

Naturopathic Center for Wellness

Practice Policies for Patients

Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN, A TRADITIONAL NATUROPATH

We have created a peaceful and holistic environment that is conducive to meet your needs, listen to your desires, concerns, and fears. As a preventative healthcare practitioners, we provide encouragement and options if you are feeling lost or confused by your current medical care or condition. Our motto is to "Trust what we feel and treat what we find." Our goal is to treat our patients and their families holistically, where the family unit will be educated, learning the importance of daily nutrition, supplementation when recommended, Cranial Sacral therapy application, and achieving total comprehensive healthcare.

We are committed to helping you obtain an optimal healthy life. We provide you with highest level of personal care: physical, emotional, mental and spiritual. We strongly believe this will enable you to experience the hidden, incredible healing power and capabilities of your individual body's needs. Understanding our Philosophy of care, making informed personal choices, desiring to heal, and accepting our guidance as practitioners, enables our patients to make good decisions in the future regarding their complete physical, emotion, and spiritual *holistic* life style.

Please read all the enclosed information carefully. Please sign and bring the completed forms to your first appointment. Along with these forms, please bring and relevant medical test results you have had in the past year.

CONTACT INFORMATION

Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN
23041 Avenida De La Carlota STE 110
Laguna Hills, CA 92653
Office: 949-273-6240
Fax: 949-273-6241

Our Office hours are Tuesday, Wednesday, and Thursday 10:00am-5:30pm

We may be reached at : 949-273-6240

Our website is www.Naturocw.com

Julie Miller's email is Jmiller@naturocw.com

If you need a timely answer, please call the office. For after hours non-urgent questions, please call the above number, leave a message and our office staff will return your call on the next business day.

For after hours urgent concerns, please call Dr. Julie on her cell phone 949-280-3795. She will not always be available at this number; However, you may leave a message and she will get back to you as soon as possible.

Emergencies

For any and all medical emergencies you are responsible to obtain medical attention, call 911 or go directly to the nearest Emergency Room.

Office Location

Naturopathic Center for Wellness is located in Laguna Hills at the end of furniture row in the 4 story Gray building.

23041 Avenida De La Carlota STE 110,
Laguna Hills, CA 92653

Website Information

Information about Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN and the Naturopathic Center for Wellness is available at our website: www.naturow.com

Financial Agreement

Your first visit is a hour and a half office consultation for \$240. Each visit thereafter are Half hour appointments or Phone consultations for \$90.

Payment is due on each day of services rendered. Payment options are cash, check or credit cards; Visa, MasterCard, American Express, Discover are accepted. There is a \$25 service charge for returned checks.

Cancellation of Appointment Policy

We require a 24-hour notice of cancellation for ALL appointments. Missed appointments are costly and take away time for other patients. All patients are important to us and we wish to please all scheduling needs. In the event of a late cancellation/missed appointment you will receive: first offense: a warning, second offense: \$25 missed appointment fee, third offense and thereafter: Full charge for appointment.

Insurance Information

The Naturopathic Center for Wellness does not bill for insurance or Medicare.

Medical Records

You may bring all previous medical records from other physicians or health care providers to your office visit. To obtain medical records you can request the records from the physician or lab in which your records are held.

Appointment and Cancellation Fees

As a courtesy to our patients, appointments will be confirmed prior to the appointed time. It is however, **the patient's responsibility to keep the schedule appointment or call to reschedule.**

Important Patient Information

- There is a 24 hour cancellation policy. We require 24 hour notice for all appointments that need to be canceled or rescheduled.
- If necessary to cancel or reschedule your appointment, you may call/text the office at 949-273-6240, email: jmiller@naturocw.com or after hours by calling Julie Miller on personal phone: 949-280-3795
- New patients undergo 90 minute office consultation for \$240.00
- Followup appointments: 30 minute phone consultation and 30 minute office appointments are available for \$90.00
- There is no charge for questions on emails, text, or phone calls to our office.

Lab Tests

- Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN may request blood lab tests, saliva, urine and /or stool tests to be completed.
- Any blood work will be preformed at an outside lab corp facility.
- Testing recommendations and costs per test will be reviewed with patient.
- Fees for lab tests are billed directly by our office or directly by the lab. Patient may inquire if the lab facility will work directly with insurance if necessary.
- You may receive a copy of your lab results from our office.

Supplements

- Whole food nutritional supplements are available for purchase at the Naturopathic Center for Wellness
- Patients are under no obligation to purchase their supplements through our office.
- Our Office can ship supplements to your home with a standard shipping fee of \$15.00
- All supplements are FINAL SALE**

Patient Awareness and Responsibility

- Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health. Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN makes no claim of cure for any condition.
- Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN will inform you of the treatment plan most relevant to your condition both conventional and alternative.
- You have the choice to accept, refuse or terminate these therapies at any time.
- By agreeing to do your best to comply with and implement that agreed upon program for you, you will receive full benefit of your visits with Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN.
- It is your responsibility to seek professional attention from Dr. Julie Miller Psc.D, RND, RN, BSN, CCWFN, TRADITIONAL NATUROPATH (Doctor Licensed by PMA. Not Licensed ND in California) or another medical facility if your conditions worsen.

-Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN will NOT ask you to stop taking any medicines prescribed by another physician. If you desire to stop taking any prescriptions, please consult the physician that prescribed the medications.

Evening and Weekend Calls

-Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN does not maintain regular calls on evenings, Mondays, Fridays nor weekends and holidays.

-If you have a non-urgent question, please call during office hours or email Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN directly. If you call, please leave a message at the office and she will respond to your question during the work days.

-If you have an urgent concern you may leave a message on Dr. Julie's personal phone 949-280-3795. She will not always be available on this number, but please leave your name and number and she will respond to you as quickly as possible.

Emergencies

-In the even of an emergency you are responsible to obtain medical attention. Call 911 or go to the nearest emergency room.

Patient Signature

Date

Indicate relation if signing for patient: _____

Patient Contact Information

Patient Name _____ Date of First Visit _____

Date of Birth _____ Parent(s)/Guardian _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

Email _____

Gender: Male _____ Female _____

Marital Status _____

Live with _____

Occupation _____

Employer _____

Emergency Contact _____ Relationship _____

Names and Contact Information for Health Care Providers from whom you are currently receiving care (or have seen within the past 12 months). And ANY Health Care Providers from whom you are obtaining prescriptions.

_____ Contact # _____

_____ Contact # _____

_____ Contact # _____

Notice of Privacy Practice (HIPPA Form) Protected Personal Health Information

Patient Giving Consent:

Name: _____ Date: _____

To The Patient: Please read the following statement carefully.

Our pledge regarding Medical Information- Purpose Consent:

By signing this form you will consent to the use and disclosure of your protected health information only with your written consent. The privacy of your medical information is important to us. We understand that your medical information is person and we are committed to protecting it. We create a record of the care and services you receive at the Naturopathic Center for Wellness. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Notice of Privacy Practice:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice Provides a description of our treatment, payment and healthcare practices, the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke:

You have the right to revoke this consent at any time by giving written notice of your revocation submitted to:

Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN
23041 Avenida De La Carlota STE 110,
Laguna Hills, CA 92653

Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment and healthcare plans.

Signature

Authorized Provider Representative

Date

Date

Patient Consent Form

Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN, A REGISTERED NATUROPATH

Naturopathic Center for Wellness

23041 Avenida De La Carlota #110

Laguna Hills, CA 92653

Name _____ Male ___ Female ___ Birth date ___/___/___

Address _____

City _____ State _____ Zip _____

Welcome to the Naturopathic Center for Wellness, an alternative, Naturopathic, holistic, educational approach to total client care. Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN, is a graduate of Mount Saint Mary's College of Nursing holding an RN, BSN and Clayton College degree where she received with highest honors a Doctorate of Naturopathy and received a Doctorate of Pastoral Science and Medicine licensed by the P.M.A. She has practiced as a registered nurse for 26 years and as a TRADITIONAL NATUROPATH since 2003. She is also an advanced practitioner of Cranial Sacral Therapy.

The Naturopathic Center for Wellness wants to help you and your family members empower yourselves. We will educate you so that you can make the best decisions for your own health care. We will discuss your health and review your personal history, making recommendations where applicable towards your care. We ask you to fill out a Client Intake Form, which will provide us the opportunity to become more familiar with you and your family.

Our approach to "Total Health Care" may include: Client Education- the physical, emotional, spiritual self, Basic Iridology, Whole Food Supplementation, Cranial Sacral Therapy, Somato-Emotional Release, Acupressure, Herbs and blended Eastern/Western Exam.

Your signature below acknowledges you have read this consent form and gives us full consent to enable you to empower yourself.

Date _____

Patient Name _____

Patient Signature _____

Indicate relationship is signing on behalf of patient

Health History Questionnaire

Present Complaint _____

Other Healthcare providers you are seeing, and their specialties _____

First Noticed? _____

of Children _____

Religion (optional) _____

Have you been Exposed to Toxic Chemicals? _____

What Diagnosis were you given? _____

WOMEN ONLY:

Age of Onset of Menstruation _____ No. Miscarriage/C-section/Abortions _____

Age of onset Menopause _____

Health as a Child? Excellent Good Fair Poor

Were there any complications with your delivery?

Explain: _____

Were you breast fed? _____ How Long? _____

Did you have any serious emotional or mental trauma as a child?

Please circle diseases for which you have been immunized?

Measles Mumps Rubella Small Pox Tetanus Diphtheria

What is your blood type? A B AB O Don't know

Allergies/Sensitives (Please Specify)

Chemicals _____

Drugs/Medications _____

Dust/Molds _____

Foods _____

Grasses/Weeds [Pollen] _____

Other _____

Test History

Please List the date of your most recent procedure and indicate any tests that were abnormal.

Health Habits

Please list all supplements, herbs, homeopathic you are currently taking.

Please Circle any of the Medications you are currently taking or have taken in last 3 months.

- | | | | |
|-------------------------|---------------------|----------------------|------------------|
| Allergy Medication | Chemotherapy | Oral Contraceptives | Ulcer Medication |
| Antacids | Cortisone | Pain Medication | Other_____ |
| Anti-Inflammatory | Heart Medication | Radiation | |
| Antibiotics/Anti-fungal | High Blood Pressure | “Recreational Drugs” | |
| Antidepressants | Hormones | Relaxants | |
| Anti-diabetic / Insulin | Laxatives | Sleeping Pills | |
| Aspirin/Tylenol/Advil | Lithium | Thyroid | |

Do you use/ Drink any of the following?

- | | | |
|---------------------------|--------------------------|-----------------------|
| ___ Tobacco | Packs per Day/Week _____ | How Many Years? _____ |
| ___ Coffee | Cups per Day/Week _____ | How Many Years? _____ |
| ___ Black Tea | Cups per Day/Week _____ | How Many Years? _____ |
| ___ Alcohol | Cups per Day/Week _____ | How Many Years? _____ |
| ___ Soda | Cups per Day/Week _____ | How Many Years? _____ |
| ___ Artificial Sweeteners | | How Many Years? _____ |

Family History

	Age	Health Problems
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
1	_____	_____
2	_____	_____
3	_____	_____
Children	_____	_____
1	_____	_____
2	_____	_____
3	_____	_____
Grandmother(M)	_____	_____
Grandfather (M)	_____	_____
Grandmother(F)	_____	_____
Grandfather(F)	_____	_____

How many times a week do you eat in a restaurant? Breakfast ___ Lunch___ Dinner___

What types of restaurants do you eat at? _____

What are your favorite foods? _____

Do you Crave Sweets? _____ At what time? _____ Do you Salt your food? _____

Are there other foods you crave? Bread Pasta Dairy Meat Other: _____

What foods do you really dislike? _____

Are you on any specific diet? Which Diet? _____

Would you like to increase or decrease your weight? If so, by how much: _____

When did you last have a significant change in weight? (More than 10lbs) _____

What exercise do you do and how often? _____

- ___ Sedentary
- ___ Mild Exercise (I.E. Climbs stairs, walk 3 blocks, golf)
- ___ Occasional Vigorous exercise (I.E. work or recreation, Less than 4x/week for 30 min.)
- ___ Regular Vigorous exercise (I.E. Work or recreation, 4x/week for 30 minutes)

How Many hours of sleep do you get each night? _____ Do you wake rested? _____

Are you Presently sexually Active? _____ Any difficulties? _____ Method of BC _____

Please Rate from 1-10 (1 being lowest and 10 being highest)

Current Stress level ___ How much does this affect you? _____

What are the major stress factors? _____

Rate your current Emotional Health: Excellent Good Fair Poor Unstable Crisis

Are you currently in Psychotherapy? _____ Do you have a good support team? _____

Does your home environment have a supportive effect on your health? _____

How many hours of relaxation do you give yourself during the work week? _____

During Weekends? _____ Favorite recreational activities? _____

When was your last Eye Exam? _____ Do you wear contacts? _____ Hard/Soft

Do you drink purified bottled water? _____ If so, what brand? _____

Do you have an air purifier in the room you sleep in? _____ What brand? _____

Do you have Amalgam (silver fillings)? _____ Any other dental problems? _____

Do you make an effort to eat organically grown foods? _____ what % _____

Are you considering any elective surgery or medical procedures in the near future? _____

Please Check the appropriate area if you have had any of the following health problems.

	NOW	PAST	Treatment / Dates
Anemia			
Anorexia/Bulimia			
Arthritis			
Asthma			
Blood pressure (high or low)			
Bone/Joint			
Cancer			
Cirrhosis/Liver Disease			
Diabetes			
Epilepsy/Seizures			
Eye Disease/Blindness			
Fibromyalgia/Muscle Pain			
Glaucoma			
Headaches			
Head Injury/ Brain Tumor			
Heart Disease			
Hepatitis/Jaundice			
Kidney Disease			
Lung Disease			
Menstrual Pain			
Oral Health/Dental			
Stomach/Bowel Problems			
Stroke			
Thyroid			
Tuberculosis			
AIDS/HIV			
STDS			
Learning Problems			
Speech Problems			
Anxiety			
Bipolar Disorder			
Depression			
Eating Disorder			
Hyperactivity/ADD			
Schizophrenia			
Sexual Problems			
Sleep Disorder			
Suicide Attempts/Thoughts			
Other			

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

- MILD symptoms (occurred once or twice last 6 months).
- MODERATE symptoms (occurred once or twice last month).
- SEVERE symptoms (chronic, occurred once or twice last week).
- Leave circles BLANK if they don't apply to you!

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 Cut heals slowly
- 8 Gag easily
- 9 Unable to relax; startles easily
- 10 Extremities cold, clammy
- 11 Strong light irritates
- 12 Urine amount reduced
- 13 Heart pounds after retiring
- 14 "Nervous" stomach
- 15 Appetite reduced
- 16 Cold sweats often
- 17 Fever easily raised
- 18 Neuralgia-like pains
- 19 Staring, blinks little
- 20 Sour stomach often

GROUP 2

- 21 Joint stiffness on arising
- 22 Muscle-leg-toe cramps at night
- 23 "Butterfly" stomach, cramps
- 24 Eyes or nose watery
- 25 Eyes blink often
- 26 Eyelids swollen, puffy
- 27 Indigestion soon after meals
- 28 Always seems hungry; feels "lightheaded" often
- 29 Digestion rapid
- 30 Vomiting frequent
- 31 Hoarseness frequent
- 32 Breathing irregular
- 33 Pulse slow; feels "irregular"
- 34 Gagging reflex slow
- 35 Difficulty swallowing
- 36 Constipation, diarrhea alternating
- 37 "Slow starter"
- 38 Get "chilled" infrequently
- 39 Perspire easily
- 40 Circulation poor, sensitive to cold
- 41 Subject to colds, asthma, bronchitis

GROUP 3

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

1 2 3

- 52 Awaken after few hours sleep - hard to get back to sleep
- 53 Crave candy or coffee in afternoons
- 54 Moods of depression - "blues" or melancholy
- 55 Abnormal craving for sweets or snacks

GROUP 4

- 56 Hands and feet go to sleep easily, numbness
- 57 Sigh frequently, "air hunger"
- 58 Aware of "breathing heavily"
- 59 High altitude discomfort
- 60 Opens windows in closed rooms
- 61 Susceptible to colds and fevers
- 62 Afternoon "yawner"
- 63 Get "drowsy" often
- 64 Swollen ankles, worse at night
- 65 Muscle cramps, worse during exercise; get "charley horses"
- 66 Shortness of breath on exertion
- 67 Dull pain in chest or radiating into left arm, worse on exertion
- 68 Bruise easily, "black and blue" spots
- 69 Tendency to anemia
- 70 "Nose bleeds" frequent
- 71 Noises in head, or "ringing in ears"
- 72 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

- 73 Dizziness
- 74 Dry skin
- 75 Burning feet
- 76 Blurred vision
- 77 Itching skin and feet
- 78 Excessive falling hair
- 79 Frequent skin rashes
- 80 Bitter, metallic taste in mouth in mornings
- 81 Bowel movements painful or difficult
- 82 Worrier, feels insecure
- 83 Feeling queasy; headache over eyes
- 84 Greasy foods upset
- 85 Stools light colored
- 86 Skin peels on foot soles
- 87 Pain between shoulder blades
- 88 Use laxatives
- 89 Stools alternate from soft to watery
- 90 History of gallbladder attacks or gallstones
- 91 Sneezing attacks
- 92 Dreaming, nightmare type bad dreams
- 93 Bad breath (halitosis)
- 94 Milk products cause distress
- 95 Sensitive to hot weather
- 96 Burning or itching anus
- 97 Crave sweets

GROUP 6

- 98 Loss of taste for meat
- 99 Lower bowel gas several hours after eating
- 100 Burning stomach sensations, eating relieves
- 101 Coated tongue
- 102 Pass large amounts of foul-smelling gas
- 103 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 Mucous colitis or "irritable bowel"
- 105 Gas shortly after eating
- 106 Stomach "bloating" after eating

- 1 2 3 GROUP 7A**
- 107 Insomnia
 - 108 Nervousness
 - 109 Can't gain weight
 - 110 Intolerance to heat
 - 111 Highly emotional
 - 112 Flush easily
 - 113 Night sweats
 - 114 Thin, moist skin
 - 115 Inward trembling
 - 116 Heart palpitates
 - 117 Increased appetite without weight gain
 - 118 Pulse fast at rest
 - 119 Eyelids and face twitch
 - 120 Irritable and restless
 - 121 Can't work under pressure

- GROUP 7B**
- 122 Increase in weight
 - 123 Decrease in appetite
 - 124 Fatigue easily
 - 125 Ringing in ears
 - 126 Sleepy during day
 - 127 Sensitive to cold
 - 128 Dry or scaly skin
 - 129 Constipation
 - 130 Mental sluggishness
 - 131 Hair coarse, falls out
 - 132 Headaches upon arising, wear off during day
 - 133 Slow pulse, below 65
 - 134 Frequency of urination
 - 135 Impaired hearing
 - 136 Reduced initiative

- GROUP 7C**
- 137 Falling memory
 - 138 Low blood pressure
 - 139 Increased sex drive
 - 140 Headaches, "splitting or rending" type
 - 141 Decreased sugar tolerance

- GROUP 7D**
- 142 Abnormal thirst
 - 143 Bloating of abdomen
 - 144 Weight gain around hips or waist
 - 145 Sex drive reduced or lacking
 - 146 Tendency to ulcers, colitis
 - 147 Increased sugar tolerance
 - 148 Women: menstrual disorders
 - 149 Young girls: lack of menstrual function

- GROUP 7E**
- 150 Dizziness
 - 151 Headaches
 - 152 Hot flashes
 - 153 Increased blood pressure
 - 154 Hair growth on face or body (female)
 - 155 Sugar in urine (not diabetes)
 - 156 Masculine tendencies (female)

- GROUP 7F**
- 157 Weakness, dizziness
 - 158 Chronic fatigue
 - 159 Low blood pressure
 - 160 Nails weak, ridged
 - 161 Tendency to hives
 - 162 Arthritic tendencies
 - 163 Perspiration increase
 - 164 Bowel disorders
 - 165 Poor circulation
 - 166 Swollen ankles
 - 167 Crave salt
 - 168 Brown spots or bronzing of skin
 - 169 Allergies - tendency to asthma

- 1 2 3**
- 170 Weakness after colds, influenza
 - 171 Exhaustion - muscular and nervous
 - 172 Respiratory disorders

- GROUP 8**
- 173 Apprehension
 - 174 Irritability
 - 175 Morbid fears
 - 176 Never seems to get well
 - 177 Forgetfulness
 - 178 Indigestion
 - 179 Poor appetite
 - 180 Craving for sweets
 - 181 Muscular soreness
 - 182 Depression; feelings of dread
 - 183 Noise sensitivity
 - 184 Acoustic hallucinations
 - 185 Tendency to cry without reason
 - 186 Hair is coarse and/or thinning
 - 187 Weakness
 - 188 Fatigue
 - 189 Skin sensitive to touch
 - 190 Tendency toward hives
 - 191 Nervousness
 - 192 Headache
 - 193 Insomnia
 - 194 Anxiety
 - 195 Anorexia
 - 196 Inability to concentrate; confusion
 - 197 Frequent stuffy nose; sinus infections
 - 198 Allergy to some foods
 - 199 Loose joints

- FEMALE ONLY**
- 200 Very easily fatigued
 - 201 Premenstrual tension
 - 202 Painful menses
 - 203 Depressed feelings before menstruation
 - 204 Menstruation excessive and prolonged
 - 205 Painful breasts
 - 206 Menstruate too frequently
 - 207 Vaginal discharge
 - 208 Hysterectomy / ovaries removed
 - 209 Menopausal hot flashes
 - 210 Menses scanty or missed
 - 211 Acne, worse at menses
 - 212 Depression of long standing

- MALE ONLY**
- 213 Prostate trouble
 - 214 Urination difficult or dribbling
 - 215 Night urination frequent
 - 216 Depression
 - 217 Pain on inside of legs or heels
 - 218 Feeling of incomplete bowel evacuation
 - 219 Lack of energy
 - 220 Migrating aches and pains
 - 221 Tire too easily
 - 222 Avoids activity
 - 223 Leg nervousness at night
 - 224 Diminished sex drive

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

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

