REVIEW OF SYSTEMS

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Account No: _____

Many of the following conditions respond to chiropractic treatment.

Are you <u>currently</u> experiencing any of these symptoms? (Please select all that apply and use comments to elaborate.)

| Constitutional: (General) ☐ Fever ☐ Fatigue | Respiratory: ☐ Difficulty Breathing ☐ Cough | Review of Systems Comments: |
|--|---|-----------------------------|
| Other: | Other: | |
| □ None in this Category | □ None in this Category | |
| Musculoskeletal: | Eves & Vision: | |
| ☐ Joint Pain/Stiffness/Swelling | ☐ Eye Pain | |
| ☐ Muscle Pain/Stiffness/Spasms | ☐ Blurred or Double Vision | |
| ☐ Broken Bones | ☐ Sensitivity to Light | |
| □ Other: | ☐ Other: | |
| ☐ None in this Category | □ None in this Category | |
| Neurological: | Head, Ears, Nose, & Mouth/Throat: | |
| Dizziness or Lightheaded | ☐ Frequent or Recurrent Headaches | |
| ☐ Convulsions or Seizures | ☐ Ear - Ache/Ringing/Drainage | |
| ☐ Tremors | ☐ Hearing Loss | |
| □ Other: | Sensitivity to Loud Noises | |
| \square None in this Category | ☐ Sinus Problems | |
| Psychiatric: (Mind/Stress) | ☐ Sore Throat | |
| □ Nervousness/Anxiety | ☐ Other: | |
| □ Depression | ☐ None in this Category | |
| ☐ Sleep Problems | Endocrine: | |
| ☐ Memory Loss or Confusion | ☐ Infertility | |
| □ Other: | Recent Weight Change | |
| None in this Category | ☐ Eating Disorder | |
| • | ☐ Other: | |
| Genitourinary: ☐ Frequent or Painful Urination | □ None in this Category | |
| □ Blood in Urine | Hamatalagia & Lymphatia | |
| ☐ Incontinence or Bed Wetting | Hematologic & Lymphatic: Excessive Thirst or Urination | |
| ☐ Painful or Irregular Periods | ☐ Cold Extremities | |
| Other: | ☐ Swollen Glands | |
| □ None in this Category | Other: | |
| • • | ☐ None in this Category | |
| Gastrointestinal: | | |
| ☐ Loss of Appetite | Integumentary: (Skin, Nails, & Breasts) | |
| ☐ Blood in Stool or Black Stool | Rash or Itching | |
| □ Nausea or Vomiting | ☐ Change in Skin, Hair, or Nails | |
| ☐ Abdominal Pain | □ Non-healing Sores or Lesions | |
| ☐ Frequent Diarrhea | ☐ Change of Appearance of a Mole | |
| Constipation | ☐ Breast Pain, Lump, or Discharge | |
| ☐ Other: | ☐ Other: | |
| • • | • | |
| Cardiovascular & Heart: | Allergic/Immunologic: | |
| ☐ Chest Pains/Tightness | ☐ Food Allergies | |
| Rapid or Heartbeat Changes | ☐ Environmental Allergies | |
| ☐ Swelling of Hands, Ankles, or Feet | Other: | |
| Other: | □ None in this Category | |
| □ None in this Category | | |
| I have answered these questions to the best of my knowledge and certify them to be true and correct. | | |
| Patient or Guardian Signature | | Date |
| Print Name: (First MI Last) | | |