Today's Date:_____ **Patient Name:**_____

What are your main reasons for today's visit_____

List X-rays, MRI's, etc. you have had for this problem in the past 5 years_____

HAVE YOU SEEN A CHIROPRACTOR THIS YEAR? **Yes or No**

HAVE YOU SEEN A PHYSICAL THERAPIST THIS YEAR? **Yes or No**

REVIEW OF SYSTEMS

Do you CURRENTLY have? (circle ALL that apply)

General
Fatigue
Fever
Weight gain?
Weight loss?
Night Sweats

Respiratory
Chronic cough
Shortness of breath
Wheezing
Asthma

Neurological
Dizziness
Headaches
Seizures
Tremors
Numbness

Gastrointestinal
Abdominal pain
Constipation
Diarrhea
Nausea/Vomiting
Urinary problems/changes

Musculoskeletal
Joint pain/Stiffness
Neck pain
Low Back pain
Muscle weakness
Muscle aches/pains

Cardiovascular
Chest pain
Palpitations
Leg swelling
Leg pain w/walking

Psychiatric
Anxiety
Depression
Hallucinations
Change in sleep pattern

HEENT
Visual Disturbances
Eye pain
Ear pain
Hoarseness

Endocrine
Appetite changes
Increased thirst
Increased urination
Cold intolerance
Hair/skin changes

Hematology
Easy bruising
Enlarged lymph nodes
Prolonged bleeding
Anemia

Other not listed:_____
_____
_____
_____
_____

PAST Medical History (Circle ALL that apply to YOU)

Anemia
Artery Disease
Arthritis-type_____
Asthma
Cancer-type_____
Chickenpox/shingles
Depression
Diabetes
Emphysema
Fibromyalgia
Gallstones
Glaucoma
Gout
Head Injury
Heart Attack/Coronary
Heartburn/GERD
Heart Failure
Hepatitis/Jaundice
High Blood Pressure
High Cholesterol
HIV/Aids
IV Drug Use
Kidney Disease
Kidney Stones
Liver Disease
Migraine
Multiple Sclerosis
Parkinsons Disease
Obstructive Sleep Apnea
Osteoporosis
Pneumonia
Polio
Positive TB skin test
Prostate Disease/Disease
Rheumatic Fever
Scoliosis
Seizures
Stroke
Substance Abuse
Thyroid Disease
Tuberculosis
Ulcer Disease
_____
_____

PAST Surgical History

Appendix
Breast
C-section
Ears
Eyes
Gall Bladder
Gastric Bypass
Heart
Hemorrhoids
Hernia
Hip
Hysterectomy
Intestine/Colon
Knee
Metal implants
Ovaries
Pacemaker
Prostate
Shoulder
Sinus
Spinal Surgery/Back
Spinal Surgery/Neck
Stomach
Thyroid
Tonsils/Adenoids
Tubal
Varicose Veins
Vasectomy

FAMILY HISTORY	**NO**	**YES**	**If yes, who? (Father, mother, sister, brother etc.)**	***LIST YOUR MEDICATIONS*** Name and Frequency and Dosage (mg)
Rheumatoid Arthritis	○	○		1.
Cancer	○	○		2.
Diabetes	○	○		3.
Heart Problems	○	○		4.
Multiple Sclerosis	○	○		5.
Lupus	○	○		6.

HABITS (How often do you)	***LIST MEDICATION ALLERGIES & REACTIONS***	***LIST VITAMINS/SUPPLEMENTS***
Smoke: Never Former- how long ago____ 0 1/2 1 2 >2 pks/day for _____yrs.	1.	1.
Drink alcohol: 0 1-3 4-7 >7 drinks/week	2.	2.
Have coffee/tea: 0 1-3 4-6 >6 cups/day	3.	3.
Drink diet drinks 0 1-3 4-6 >6 cups/day	4.	4.
Drink regular soda: 0 1-3 4-6 >6 cups/day	5.	5.
Drink water: 0 1-3 4-6 >6 cups/day	**RECREATIONAL DRUG USE:**	

WHAT TYPE OF REGULAR EXERCISE DO YOU PERFORM? ○ None ○ Light ○ Moderate ○ Strenuous

Explain Type of Exercise/ Equipment used_____

_____

__

FEMALES ONLY	Never	Past 90 days	Any History	
Birth control pills	☐	☐	☐	What kind of birth control pills?
Hormonal replacement therapy	☐	☐	☐	
Endometriosis	☐	☐	☐	
Last Mammogram	☐	☐	☐	When?

	Pregnant Patient Section Only		**Children Under 12 Section Only**

Who is your OB/GYN physician?
_____
How far along are you?
_____
When is your expected due date? _____
Are you on any restrictions? _____

Yes	No	
☐	☐	Are you taking prenatal vitamins?
☐	☐	Are you Anemic? Type_____
☐	☐	Do you have a history of post-partum depression?
☐	☐	Do you have a history of blood clots?

Other:
_____

Who is your child's Pediatrician?
_____

Yes	No	
☐	☐	Has your child had an ear infection in the past year?
☐	☐	Has your child ever been screened for scoliosis? When? _____
☐	☐	Has your child been on antibiotics in the past 90 days? Why? _____
☐	☐	Does your child take multi-vitamins?

What activities does your child participate in?
_____
__

Other:
_____