Account#_____

Name:_____ Date: _____ DOB: _____/_____/_____

Review of Systems

(Check all that apply)

	Night sweats		Impotence
	Lack of energy		Pain in joints
	Unexplained weight loss or gain		Swelling in joints:
	Facial pain or numbness		Rashes
	Nose bleeds		Skin lesions
	Nasal drip		Hair loss/increase
	Mouth sores		Double vision
	Irregular heart beat		Poor balance
	Chest pains		Visual loss
	Swollen legs or feet		Tremors
	Pain in legs with walking		Headaches
	Shortness of breath		Anxiety
	Prolonged cough		Depression
	Coughing up blood		Intolerance to heat/cold
	Heart burn		Menstrual problems
	Constipation		Easy Bruising
	Diarrhea		Frequent thirst
	Incontinence		Easy bleeding
	Painful or frequent urination		Blood diseases
	Prostate problems		Seasonal allergies
	Change in sex drive/energy level		Infections
	Anemia		Other:

Family History

(Please check and **identify the family member** who has/had the condition)

	Cancer:		Heart Disease:
	Stroke:		Diabetes:
	Cystic Fibrosis:		Back Problems:
	Rheumatoid Arthritis:		High Blood Pressure:
	Migraines:		Skin Lesions:
	Lupus:		Other:

Implantable Devices

☐ I have no implanted devices ☐ I have a _____implanted.

Social History

Number of children_____ Alcohol usage: drinks per day? _____ Caffeinated beverages per day? _____
Tobacco usage: ☐ Never or _____ packs/day for _____ years. Date quit _____ (year)
Advanced Directive: ☐ Yes ☐ No ☐ I do not know Do you use illegal drugs? ☐ Yes ☐ No
Employer_____ Job Title_____
☐ Retired ☐ Unemployed ☐ Permanently Disabled, If yes, when _____
Level of Education_____

I have read the information provided and answered the questions truthfully to the best of my knowledge, and hereby authorize this office to provide a chiropractic exam and if agreed on care, in accordance with this state's statues.

Patient or Legal Guardian signature X_____ Date X_____