Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Review of Systems

(Check all that apply)

CONSTITUTIONAL: fevers, chills, night sweats, severe fatigue, body ache.

HEENT: headaches, blurry vision, eye pain, tinnitus (ringing in your ears), vertigo, gum bleeding, sore throat, neck or thyroid masses.

RESPIRATORY: cough, sputum, hemoptysis (bloody cough), shortness of breath

CARDIAC: chest pain, pressure, palpitations, irregular heartbeats, fainting,

lower leg edema (swelling).

GASTROINTESTINAL: abdominal pain, changes in bowel habits or any bleeding on toilet paper/toilet.

GENITOURINARY: dysuria (painful urination), incontinence, hematuria (blood in urine), nocturia (night urination more than 3 times) or frequency.

NEUROLOGIC: dizziness, tingle or numbness in face, tingle or numbness in arms, legs, feet or hands, poor balance, difficulty concentrating

VASCULAR: claudication (pain in legs causing a limp), swelling in legs,

cramping in arms or legs, discolored arms/legs

ENDOCRINOLOGY: heat or cold intolerance; hair loss, excessive weight loss (10 pounds or more in a month), excessive weight gain

HEMATOLOGY: easy bleeding, easy bruising

DERMATOLOGY: changes in moles, rashes, very dry skin

PSYCHIATRY: change in behavior, memory loss, depression, agitation, or anxiety

MUSCULOSKELETAL: multiple joint pain, joint swelling

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fairfield Spine and Rehab Center, LLC, 2217 W. Fair Ave., Lancaster, OH 43130 (740) 654-3375