EVANS CHIROPRACTIC

Review of Systems

Mark each item below for each sign/symptom you have now or previously have had in the past 30 days:

GENERAL SYMPTOMS
___ Convulsions
___ Dizziness
___ Fainting
___ Headache
___ Nervousness
___ Numbness
___ Wheezing

MUSCLES & JOINTS
___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Sprains/strains
___ Broken bones
___ Hip pain L / R
___ Ankle pain L / R
___ Knee pain L / R
___ Elbow pain L / R
___ Shoulder pain L / R
___ Wrist pain L / R

GENITO-URINARY
___ Blood in urine
___ Frequent urination
___ Kidney infection
___ Painful urination
___ Prostate problems
___ Loss of bladder control
___ Groin pain

GASTRO-INTESTINAL
___ Significant gas
___ Bloating
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gall bladder issues
___ Liver trouble
___ Nausea
___ Abdominal pain
___ Ulcer
___ Poor appetite
___ Diabetes
___ Vomiting
___ Vomiting blood
___ Black/bloody stool
___ Weight loss/gain

RESPIRATORY
___ Asthma
___ Chronic cough
___ Difficulty breathing
___ Spitting blood
___ Spitting phlegm

CARDIOVASCULAR
___ High blood pressure
___ Heart attack
___ Chest pain
___ Irregular heartbeat
___ Poor circulation
___ Heart issues
___ Rapid heart beat
___ Strokes
___ Swelling ankles
___ Varicose veins

EAR/NOSE/THROAT
___ Earache
___ Ringing in ears
___ Discharge from ears
___ Enlarged thyroid
___ Frequent colds
___ Hay fever
___ Nasal blockage
___ Nose bleeds
___ Pain behind eyes
___ Persistent cough
___ Blurry vision
___ Sinus problems
___ Sore throats

SKIN OR ALLERGIES
___ Bruising easily
___ Dryness
___ Eczema/rash
___ Itching
___ Allergy
___ Sores won't heal

FOR WOMEN ONLY
___ Birth control _____
___ Hormone replacement
___ Cramps/backaches
___ Irregular cycle
___ Painful periods

Pregnant at this Time Y/N

Other:_____

_____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____