EVANS CHIROPRACTIC

Review of Systems

Mark each item below for each sign/symptom you have now or previously have experienced:

GENERAL SYMPTOMS
___ Dizziness
___ Fainting
___ Headache
___ Numbness
___ None

MUSCLES & JOINTS
___ Low back problems
___ Pain between shoulders
___ Neck pain
___ 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
___ None

GENITO-URINARY
___ Frequent/painful urination
___ Kidney infection
___ Loss of bladder control
___ Groin pain/numbness
___ None

RESPIRATORY
___ Asthma
___ Chronic cough
___ Difficulty breathing
___ Wheezing
___ None

GASTRO-INTESTINAL
___ Significant gas
___ Bloating
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gallbladder issues
___ Liver issues
___ Nausea
___ Abdominal pain
___ Ulcer
___ Poor appetite
___ Diabetes
___ Vomiting
___ Vomiting blood
___ Black/bloody stool
___ Weight loss/gain
___ None

CARDIOVASCULAR
___ High blood pressure
___ Heart attack history
___ Chest pain
___ Irregular heartbeat
___ Poor circulation
___ Rapid heart beat
___ Stroke history
___ Swelling ankles
___ Varicose veins
___ None

SKIN OR ALLERGIES
___ Bruising easily
___ Dryness
___ Eczema/rash
___ Sores won't heal
___ None

EAR/NOSE/THROAT
___ Earache
___ Ringing in ears
___ Nasal blockage
___ Nose bleeds
___ Pain behind eyes
___ Persistent cough
___ Sinus problems
___ Sore throats
___ None

FOR WOMEN ONLY
___ Birth control _____
___ Hormone replacement
___ Cramps/backaches
___ Irregular cycle
___ Painful periods
___ None

Pregnant at this Time Y/N

Other:_____
_____
_____
_____

Medications:_____
_____
_____
_____
_____
_____

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_____