Patient	t Name:	Date
1.	Describe your symptoms	
2.	 How often do you experience your symptoms? (1) Constantly (76-100% of the day) (2) Frequently (51-75% of the day) (3) Occasionally 26-50% of the day) (4) Intermittently (0-25% of the day) 	Indicate where you have pain or symptoms
3.	What describes the nature of your symptoms?1) Sharp(4) Shooting(2) Dull ache(5) Burning(3) Numb(6) Tingling	
4.	 How are your symptoms changing? ① Getting Better ② Not Changing ③ Getting Worse 	
5.	During the past 4 weeks: a. Indicate the average intensity of your symptoms b. How much has pain interfered with your normal w (1) Not at all (2) A little bit (3) Mode	NoneUnbearable①②③④⑤⑦⑧⑩①②③④⑤⑦⑧⑩⑩ork (including both work outside the home, & housework) erately④Quite a bit⑤Extremely
6.	(like visiting with friends, relatives, etc.)	r condition interfered with your social activities? me of the time ④A little of the time ⑤None of the time
7.	In general would you say your overall health right now (1) Excellent (2) Very Good (3) Goo	
8.	a. What treatment did you receive and when?b. What tests have you had for your symptoms ar	octor ④ Physical Therapist ⑤Other ④ when were they performed? Scan date: ④ Other date:
9.	 Have you had similar symptoms in the past? ①Yes a. If you have received treatment in the past for th ①This Office ②Other Chiropractor ③ Medical Dot 	ne same or similar symptoms, who did you see?
10.). What is your occupation?	
	 Professional/Executive White Collar/Secretari Homemaker FT Student Retired a. If you are not retired, a homemaker, or a studer Full-time Part-time Self-employed un 	(8)Other nt, what is your current work status?

Review of Systems

Circle Yes or No

Constitutional Symptoms		<u>Respiratory</u>	
Activity change	Yes / No	Chest tightness	Yes / No
Appetite change	Yes / No	Choking	Yes / No
Diaphoresis/sweating	Yes / No	Cough	Yes / No
Fatigue	Yes / No	Shortness of breath	Yes / No
Fever	Yes / No	Wheezing	Yes / No
Unexpected weight loss	Yes / No	-	
Unexpected weight gain	Yes / No	<u>Cardiovascular</u>	
		Hypertension	Yes / No
Head, Ears, Eyes, Nose and Throat		Chest Pain	Yes / No
Congestion	Yes / No	Swelling of feet, ankles, or hands	Yes / No
Dental problems	Yes / No	Palpitations	Yes / No
Drooling	Yes / No		
Ear discharge	Yes / No	Gastrointestional	
Ear pain	Yes / No	Abdominal pain	Yes / No
Facial swelling	Yes / No	Change in bowel movements	Yes / No
Hearing loss	Yes / No	Constipation	Yes / No
Nose bleeds	Yes / No	Diarrhea	Yes / No
Sinus pain	Yes / No	Nausea	Yes / No
Tinnitus (ringing/buzzing in ears)	Yes / No		
Trouble swallowing	Yes / No	<u>Neurological</u>	
Blurred or double vision	Yes / No	Dizziness	Yes / No
Vomiting	Yes / No	Facial asymmetry	Yes / No
		Headaches	Yes / No
<u>Genitourinary</u>		Ligh-headedness	Yes / No
Difficulty urinating	Yes / No	Numbness or tingling	Yes / No
Flank pain	Yes / No	Seizures	Yes / No
Hematuria (blood in urine)	Yes / No	Speech difficulty	Yes / No
Menstrual problems	Yes / No	Syncope (fainting)	Yes / No
Pelvic Pain	Yes / No	Tremors	Yes / No
		Weakness	Yes / No
<u>Musculoskeletal</u>			
Joint pain	Yes / No	Hematologic (deals with blood)	
Back pain	Yes / No	Bruise easily	Yes / No
Trouble walking	Yes / No	Anemia	Yes / No
Joint swelling	Yes / No	Swollen lymph nodes	Yes / No
Joint stiffness	Yes / No		
Muscle cramps	Yes / No	<u>Psychiatric</u>	_
Muscle aches	Yes / No	Confusion	Yes / No
Neck pain	Yes / No	Decreased concentration	Yes / No
Neck stiffness	Yes / No	Hyperactive	Yes / No
		Nervous/Anxious	Yes / No
		Depression	Yes / No
		Self-injury	Yes / No
		Suicidal ideas	Yes / No

Sleep disturbance

Yes / No