PATIENT HISTORY / REVIEW OF SYSTEMS

Name: ______________________________ Date: ______________________________

Please tell us if YOU or a member of YOUR IMMEDIATE FAMILY have had any of the following.

	Individual		Family Member	
Back pain / Leg pain	Yes	No	Yes	No
Neck Pain / Arm Pain	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Neurological Disease / Headaches / Seizures	Yes	No	Yes	No
Heart / Circulatory Problems	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Stomach or Bowel Problems	Yes	No	Yes	No
Broken Bones	Yes	No	Yes	No
Skin Disease	Yes	No	Yes	No
Prostate Disease / Hormone Therapy	Yes	No	Yes	No
Depression, Anxiety, etc.	Yes	No	Yes	No
Painful or Irregular Menstrual Cycles	Yes	No	Yes	No
Tendonitis	Yes	No	Yes	No
Exercise on a regular basis	Yes	No	Yes	No
Motor Vehicle Accident or Other Injuries	Yes	No	Yes	No
Alcohol / Nicotine	Yes	No	Yes	No
Nicotine	Yes	No	Yes	No
Allergies/Upper respiratory infection/flu/cough	Yes	No	Yes	No
Surgeries	Yes	No	Yes	No
Chiropractic Treatment Before	Yes	No	Yes	No
Unintended weight gain / loss	Yes	No	Yes	No
Recent international travel	Yes	No	Yes	No

Please explain any "Yes" answers above:

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