

FAMILY CHIROPRACTIC CLINIC

1671 W. Stems Rd
Temperance, Michigan 48182
Telephone: (734) 847-9200

REVIEW OF SYSTEMS FORM

PATIENT'S NAME: _____ **DATE:** _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:

- ANY RECENT WEIGHT GAIN/LOSS _____
- WEAKNESS _____
- FATIGUE _____
- FEVER _____
- FAINTING SPELLS _____
- NAUSEA _____
- VOMITING _____
- BALANCE PROBLEMS _____
- JAW PAIN (TMJ) _____
- NECKPAIN _____
- NECK STIFFNESS _____
- SHOULDER PAIN _____
- ARM PAIN _____
- WRIST/HAND PAIN _____
- NUMBNESS ARMS OR HAND _____
- UPPER BACK PAIN _____
- LOWER BACK PAIN _____
- HIP PAIN _____
- LEG PAIN _____
- ANKLE/FOOT PAIN _____
- NUMBNESS LEGS OR FEET _____
- JOINT SWELLING _____
- TENSION _____
- NERVOUSNESS _____
- ANXIETY _____
- IRRITABILITY _____
- SLEEPING PROBLEMS *Insomnia* _____
- DEPRESSION _____
- LIVER PROBLEMS _____
- CANCER (IF YES INDICATE WHEN AND TYPE) _____

METAL IMPLANTS (IF YES, INDICATE WHEN AND WHERE

HEAD:

- HEADACHES _____
- LOSS OF CONSCIOUSNESS _____
- DIZZINESS _____
- MEMORY PROBLEMS _____
- SEIZURES/CONVULSIONS _____

EYES:

- WEAR EYE GLASSES/CONTACT _____
- DOUBLE VISION _____
- BLURRED VISION _____
- LOSS OF VISION _____
- EYES SENSITIVE TO LIGHT _____

EARS:

- LOSS OF HEARING _____
- RINGING/BUZZING IN EARS (TINNITIS) _____
- EAR INFECTIONS _____
- VERTIGO (DIZZINESS) _____
- ANY DISCHARGE FROM EARS _____

NOSE:

- SINUS PROBLEMS _____
- EPITAXIS (NOSEBLEEDS) _____
- LOSS OF SMELL _____
- ANY DISCHARGE FROM NOSE _____

MOUTH/THROAT:

- TOOTH PAIN _____
- ANY LESIONS/SORES IN MOUTH, LIPS OR GUMS _____
- FREQUENT SORE THROATS _____
- DIFFICULTY SWALLOWING _____
- THYROID PROBLEMS _____

RESPIRATORY (LUNG PROBLEMS):

- DIFFICULTY BREATHING _____
- CHRONIC COUGH _____
- ASTHMA _____
- BRONCHITIS _____
- EMPHYSEMA _____
- EVER HAVE TUBERCULOSIS OR PNEUMONIA _____
- DATE OF LAST CHEST RADIOGRAPH _____

CARDIOVASCULAR (HEART PROBLEMS):

- CHEST PAIN _____
- DIFFICULTY BREATHING (SHORTNESS OF BREATH) _____
- PALPITATIONS _____
- NIGHT SWEATS _____
- COLD EXTREMITIES _____
- HIGH BLOOD PRESSURE _____
- LOW BLOOD PRESSURE _____
- HEART MURMUR _____
- EVER HAVE AN ECG/EKG _____

GI (GASTRO-INTESTINAL):

- UPSET STOMACH _____
- LOSS OF APPETITE _____
- INDIGESTION _____
- CONSTIPATION _____
- DIARRHEA _____
- BLOODY STOOL _____
- ABDOMINAL PAIN _____
- EXCESSIVE GAS _____
- LOSS OF BOWEL CONTROL _____