REVIEW OF SYSTEMS (COMPLETE) Mark all of the following conditions that you currently have

CONSTITUTIONAL	MUSCULOSKELETAL	NEUROLOGICAL	CARDIOVASCULAR	RESPIRATORY
○ Fever	○ Back Pain	○ Sudden Numbness	○ High Blood Pressure	○ Asthma
○ Weight Loss	○ Headaches	○ Sudden Headaches	○ Heart Disease	○ COPD
○ Obesity	○ Extremity Pain	○ Loss of Sensation	○ Arterial Aneurysm	○ Common Cold
○ Loss of Appetite	○ Bone Demineralization	○ Confusion	○ Angina	○ Emphysema
○ Fatigue	○ Unstable Fracture	○ Dizziness	○ Irregular Heart Beat	○ Pneumonia
○ Anxiety	○ Spinal Infection	○ Slurred Speech	○ Bleeding Disorder	○ Cancer
○ Allergies	○ Spinal Bone Tumors	○ Loss of Balance	○ Heart Attack	○ Pneumothorax

EYES	E,N,M,T	GENITOURINARY	GASTROINTESTINAL	DISEASE HISTORY
○ Vision Trouble	○ Hearing Loss	○ Kidney Infection	○ Diarrhea	○ Stroke
○ Double Vision	○ Tinnitus	○ Loss Bladder Control	○ Blood in Stool	○ Heart Attack
○ Night Blindness	○ Vertigo	○ Urine Color Change	○ Abdominal Pain	○ Diabetes
○ Glaucoma	○ Nose Bleeds	○ Painful Urination	○ Liver/Gall Condition	○ Cancer
○ Cataracts	○ Dry Mouth	○ Urine Leakage	○ Nausea/Heartburn	○ HIV/AIDS
○ Discharge	○ Change in Taste	○ Urgency	○ Loss Bowel Control	
○ Droopy Eyelids	○ Bleeding Gums	○ Blood in Urine	○ Prostate Problems	

PAST HISTORY & SOCIAL HISTORY					
How often do you exercise?	○ Never	○ 1x/week	○ 2x/week	○ 3x/week	○ 4x/week
How often do you use tobacco?	○ Never	○ Daily	○ Weekly	○ Monthly	○ Yearly
How many alcoholic beverages do you drink each week?					
How many coffee beverages do you drink each week?					
How many soda or sugar beverages do you drink each week?					
List all prescription medications you are currently taking.					
List all the over-the-counter medications and nutritional supplements you are currently taking.					
List all of the surgical procedures that you have had.					
List all of the times you have been hospitalized.					
List all significant past traumas that you have had.					

HEALING HANDS CHIROPRACTIC

PATIENT CASE HISTORY

We are glad that you are here today. If you have and question concerning our policies, forms, or procedures, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

PATIENT INFORMATION	
Last Name	First Name
Date of Birth	Age

CHIEF COMPLAINT

What is the reason for your visit?

When did your chief complaint begin?

Are you here because injured at work, in a motor vehicle collision or in another accident?

Mark the severity of your chief complaint as it is **right now**.

1	2	3	4	5	6	7	8	9	10
No Symptoms	Slight Discomfort	Does Not Affect Activities	Affects Personal Activities	Prevents Personal Activities	Limits My Work Schedule	Prevents All Work Activities	Prevents All Activities	Keeps Me Bedridden	Causes Thoughts Of Suicide

Mark the severity of your chief complaint as it is on **average**.

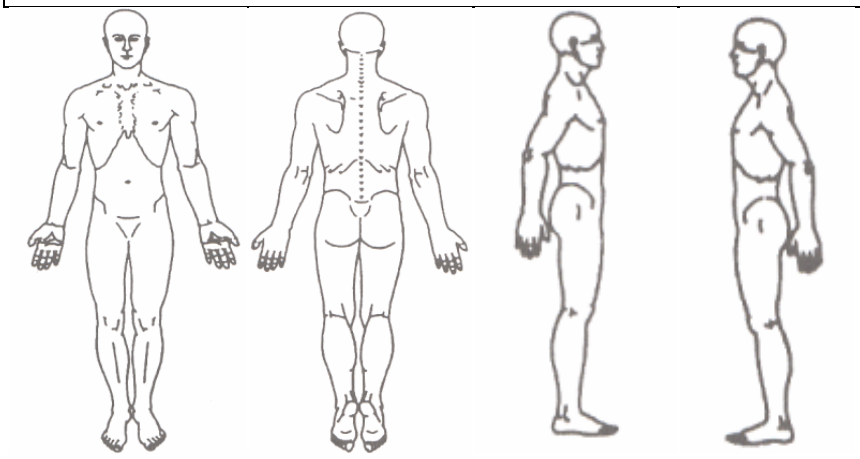
1	2	3	4	5	6	7	8	9	10
No Symptoms	Slight Discomfort	Does Not Affect Activities	Affects Personal Activities	Prevents Personal Activities	Limits My Work Schedule	Prevents All Work Activities	Prevents All Activities	Keeps Me Bedridden	Causes Thoughts Of Suicide

Mark the severity of your chief complaint as it is **at its best**.

1	2	3	4	5	6	7	8	9	10
No Symptoms	Slight Discomfort	Does Not Affect Activities	Affects Personal Activities	Prevents Personal Activities	Limits My Work Schedule	Prevents All Work Activities	Prevents All Activities	Keeps Me Bedridden	Causes Thoughts Of Suicide

Mark the severity of your chief complaint as it is **at its worst**.

1	2	3	4	5	6	7	8	9	10
No Symptoms	Slight Discomfort	Does Not Affect Activities	Affects Personal Activities	Prevents Personal Activities	Limits My Work Schedule	Prevents All Work Activities	Prevents All Activities	Keeps Me Bedridden	Causes Thoughts Of Suicide



Mark all the area of your chief complaint on the diagrams to the left. Include any description or comment that you feel are important.

If you symptoms travel to any other part of your body, mark the diagram to reflect how the symptoms seem to move