Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Patient Name: _____ File #: _____ Date: _____

ARE YOU *CURRENTLY EXPERIENCING* OR HAVE YOU HAD A *SIGNIFICANT HISTORY* WITH ANY OF THE FOLLOWING SYMPTOMS? PLEASE INDICATE BELOW.

General, Constitutional		**Musculoskeletal**	
Good general health lately	no yes	Muscle pain or cramps	no yes
Recent weight change	no yes	Joint swelling	no yes
Fever	no yes	Weakness of muscles/joints	no yes
Fatigue	no yes	Cold hands or feet	no yes
Out of shape/Overweight	no yes	One leg shorter than the other	no yes
Cancer	no yes	Difficulty in walking	no yes
Eyes and Vision		Foot/Ankle/Knee/Hip pain	no yes
Eye disease or injury	no yes	Orthotics	no yes
Wear glasses or contact lenses	no yes	**Skin and Breasts**	
Blurred or double vision	no yes	Rash or itching	no yes
Ears, Nose, and Throat		Change in skin color	no yes
Hearing loss	no yes	Breast lump	no yes
Ringing in the ears	no yes	Breast pain	no yes
Earaches or drainage	no yes	Breast discharge	no yes
Sinus problems	no yes	**Neurological**	
Swollen glands in neck	no yes	Paralysis	no yes
Nose bleeds	no yes	Frequent/recurrent headache	no yes
Bleeding gums	no yes	Light headed or dizzy	no yes
Sore throat or voice change	no yes	Head injury	no yes
Heart, Cardiovascular		Stroke	no yes
Pacemaker	no yes	Tremors	no yes
Swelling of feet, ankles, hands	no yes	Numbness or tingling	no yes
Heart trouble	no yes	Convulsions or seizures	no yes
Chest pains	no yes	**Endocrine**	
Sudden heartbeat changes	no yes	Dry skin	no yes
Respiratory		Heat/cold intolerance	no yes
Spitting up blood	no yes	Glandular/hormone problem	no yes
Frequent coughing	no yes	Change in hat/glove size	no yes
Painful bowel movements	no yes	Thyroid disease	no yes
Blood in stool	no yes	Diabetes	no yes
Loss of appetite	no yes	Excessive thirst/urination	no yes
Loss of bowel/bladder control	no yes	**Hematologic/Lymphatic**	
Stomach pain	no yes	Anemia	no yes
Nausea or vomiting	no yes	Transfusions	no yes
Genitourinary		Swollen glands	no yes
Burning or painful urination	no yes	**Psychiatric**	
Irregular periods	no yes	Memory loss or confusion	no yes
Kidney stones	no yes	Sleep problems	no yes
Frequent urination	no yes	Depression	no yes
Incontinence or dribbling	no yes	Anxiety	no yes
Blood in urine	no yes		

Patient Signature _____

I have read and reviewed the above information with the patient. _____