HEINEN CHIROPRACTIC, S.C.

Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY.

Please check the boxes for each symptom you have experienced — including past and present.

REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)		
Cervical	*General Health* *Immune System* *Eyes, Ears, Nose, Mouth*	☐☐ Colic / Crying ☐☐ Difficulty Sleeping ☐☐ Weight Change ☐☐ Allergies ☐☐ Ear Infection ☐☐ Sore Throat / Strep ☐☐ CTS ☐☐ Balance Problem	☐☐ Vertigo / Dizziness ☐☐ Epilepsy / Seizures ☐☐ Memory Issue ☐☐ Flu or Cold ☐☐ Sinus Congestion ☐☐ Swollen Tonsils ☐☐ Hand Numbness ☐☐ TMJ / Jaw Pain	☐☐ Low Energy ☐☐ ADD / ADHD ☐☐ Anxiety / Depression ☐☐ Eye Problem ☐☐ Ear Noises ☐☐ Neck Pain ☐☐ Headache / Migraine
Thoracic	*Cardiovascular* *Respiratory* *Upper Digestion* *Urinary*	☐☐ High Blood Pressure ☐☐ Poor Circulation ☐☐ Asthma ☐☐ Nausea ☐☐ Gas Pain / Bloating ☐☐ Dialysis ☐☐ Difficulty Urinating	☐☐ Low Blood Pressure ☐☐ Ankle Swelling ☐☐ Bronchitis ☐☐ Acid Reflux / G.E.R.D. ☐☐ Gall Stones ☐☐ Bed Wetting ☐☐ Painful Urination	☐☐ Irregular Heartbeat ☐☐ Chronic Cough ☐☐ Poor Appetite ☐☐ Burping / Gas ☐☐ Skin Condition / Rash ☐☐ Bladder / Urination Issues ☐☐ Upper Back Pain
Lumbar **Sacral**	*Lower Digestion* *Hormone Control*	☐☐ Constipation ☐☐ Colitis ☐☐ Endometriosis ☐☐ Infertility ☐☐ Sciatica / Leg Pain	☐☐ Diarrhea ☐☐ IBS ☐☐ Irregular Cycle ☐☐ Prostate Issues ☐☐ Neuropathy	☐☐ Crohn's Disease ☐☐ Menstrual Issues ☐☐ Hot Flashes ☐☐ Lower Back Pain ☐☐ Foot Numbness

Family History

Check any conditions that you or your immediate family has or has had in the past.

SELF / FAMILY				
☐☐ Gout	☐☐ Rheumatoid Arthritis	☐☐ Other Arthritis	☐☐ Psoriasis	☐☐ Degenerative Discs
☐☐ Shingles	☐☐ Bell's Palsy	☐☐ Ulcers	☐☐ Kidney Stones	☐☐ Appendicitis
☐☐ Parkinson's	☐☐ Multiple Sclerosis	☐☐ Cancer	☐☐ Diabetes	☐☐ Raynaud's Syndrome
☐☐ Stroke / TIA	☐☐ Heart Attack	☐☐ Back / Neck Surgery	☐☐ Pacemaker	☐☐ Defibrillator

Surgeries and dates:_____

_____

Broken bone history and dates:_____

Motor vehicle collisions and dates:_____

Do you wear orthotics, heal lifts, or arch supports?_____ For how long?_____

Previous chiropractor name:_____ Last adjustment:_____

What was the primary reason for your previous chiropractic care?

- ☐ Relief Care — Temporary relief of pain or discomfort symptoms.
- ☐ Corrective Care — Correcting, relieving & stabilizing spinal misalignments.
- ☐ Wellness Care — Seeking optimal health & function by reducing nerve interference.

Signature:_____ Date:_____