about life chiropractic
A B C D

9845 E 116th Street, Suite 300, Fishers IN 46037

Patient History

Date: _____

What symptoms prompted you to seek care today? _____

When did these symptoms start? How did they start? _____

What have you done to relieve the symptoms?

- ☐ Prescription medication
- ☐ Over-the-counter drugs
- ☐ Chiropractic
- ☐ Ice
- ☐ Heat
- ☐ Other_____

What else should About Life know about your current condition? _____

Prior illnesses, operations, injuries, and/or treatments:_____

_____

Previous imaging? (i.e. x-ray, MRI, CT scan) _____

If yes: From where? _____

What was imaged? _____

Allergies? _____

Tobacco Use? _____

Medications or supplements? _____

_____

To the best of my knowledge, the information I have provided is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Signature Date

_____

If the patient is a minor, print child's full name

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Review of systems – circle all that apply

Musculoskeletal

- Osteoporosis
- Arthritis
- Rheumatoid Arthritis
- EDS
- Sjogren
- Collagen Disorders
- Neck pain
- Back pain
- Leg cramps
- TMJ
- Osteopenia
- Other _____

Neurological

- Headaches
- Migraines
- Dizziness
- Numbness
- Vertigo
- Pins & Needles
- Issues with vision
- Issues with hearing
- Other_____

Psychiatric

- Anxiety
- Depression
- Bipolar disorder
- Mood changes
- Dementia
- Nervousness
- Tension
- Problems with change
- Other_____

Cardiovascular

- Heart disease
- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- High Cholesterol
- Shortness of breath with exertion
- Arrhythmias
- Cough
- Shortness of breath without exertion
- Other_____

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Integumentary

- ○ Skin cancer
- ○ Psoriasis
- ○ Eczema
- ○ Acne
- ○ Hair Loss
- ○ Rash
- ○ Other _____
- ○ Swelling
- ○ Discoloration
- ○ Cellulitis

Genitourinary

- ○ History of Kidney Stones
- ○ Kidney Disease
- ○ UTI symptoms
- ○ Incontinence
- ○ Bedwetting
- ○ History of Infertility
- ○ PMS Symptoms
- ○ Pelvic Pain
- ○ Prostate Issues
- ○ History of Prostate Cancer
- ○ Hysterectomy: ___Total ___Partial ___Radical
- ○ Other_____

Lymphatic

- ○ Swelling of lymph nodes in the neck
- ○ Pain in the lymph nodes of the neck
- ○ Swelling of lymph nodes in the armpit
- ○ Pain in the lymph nodes of the armpit
- ○ Swelling of lymph nodes in the groin
- ○ Pain in the lymph nodes of the groin
- ○ Swelling of lymph nodes in the legs
- ○ Pain in the lymph nodes of the legs

Endocrine

- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Heat or Cold intolerance
- ○ Diabetes
- ○ Prediabetic
- ○ Excessive Thirst
- ○ Excessive Hunger
- ○ Excessive sweating
- ○ Change in hand size
- ○ Change in feet size
- ○ Other_____

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Constitutional

- ○ Fainting
- ○ Fatigue
- ○ Weakness
- ○ Night Sweats
- ○ Poor Appetite
- ○ Sudden weight gain
- ○ Sudden weight loss
- ○ Other_____

Hematological

- ○ Hepatitis
- ○ Bleed easily (clotting issues)
- ○ Anemia
- ○ Non-Alcoholic Fatty Liver
- ○ Other _____
- ○ Alcoholic Fatty Liver

Respiratory

- ○ Asthma
- ○ History of Bronchitis
- ○ History of Pneumonia
- ○ COPD
- ○ Emphysema
- ○ History of Lung cancer
- ○ Wheezing
- ○ Pain of chest wall
- ○ Cough
- ○ Other_____

Gastrointestinal

- ○ SIBO
- ○ Ulcers
- ○ Celiac
- ○ Crohn's Disease
- ○ History of colon cancer
- ○ Hemorrhoids
- ○ Bowel Changes
  ___Diarrhea
  ___Constipation
- ○ Trouble swallowing
- ○ Abdominal pain
- ○ Vomiting
- ○ Nausea
- ○ History of Abdominal Surgery _____
- ○ GERD/Reflux/Heartburn
- ○ Alcohol Use
  ___None
  ___1-3 per week
  ___>3 per week
- ○ Other_____

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_____ _____

Signature Date