MEDICAL HISTORY CONTINUED

REVIEW OF SYMPTOMS: Below is a list of symptoms that may seem unrelated to your appointment. However, they must be answered carefully as they can affect your overall course of care.

(Circle) if you have any of the symptoms or problems listed below.

EYES/VISION change in vision wears glasses/contacts	SKIN history of skin disorders
RESPIRATION asthma cough shortness of breath	HEMATOLOGIC bruise easily fatigue
GASTRINESTINAL constipation diarrhea nausea	ENDOCRINE diabetes thyroid
PSYCHOLOGIC anxiety behavioral change bi-polar disorder depression	EARS/NOSE/THROAT dizziness headaches nasal congestion ringing in ears TMJ problems history of head injury

PREVIOUS CHIROPRACTIC CARE

☐ Not applicable

Doctor's name:_____ Date of last visit:_____

Type of treatment:_____

Were you satisfied with your care? YES or NO

If no, explain:_____

Do you wear any of the following? Heel lifts Innersoles Orthotics

Other:_____ For long?:_____