Review of Symptoms

Patient Name: _____ Date: _____
Check off any conditions you are currently suffering from or have in the past:

Musculoskeletal
☐Arthritis ☐ Scoliosis ☐ Poor Posture ☐ Back Pain ☐ Neck Pain ☐ Shoulder Pain/Injury ☐ Knee Pain/Injury ☐ TMJ

Respiratory
☐ Asthma ☐ Apnea ☐ Emphysema ☐ Shortness of Breath ☐ Chronic Bronchitis ☐ Pneumonia ☐ Tuberculosis

Neurological
☐ Headaches ☐ Dizziness ☐ Numbness ☐ Tingling ☐ Seizures ☐ Strokes ☐ Anxiety ☐ Depression

Cardiovascular
☐ High Blood Pressure ☐ High Cholesterol ☐ Angina ☐ Pacemaker ☐ Ankle Swelling ☐ Excessive Bruising

Endocrine
☐ Diabetes ☐ Thyroid Imbalance ☐ Menstrual Disorders

Digestive
☐ Heartburn ☐ Ulcer ☐ Constipation ☐ Diarrhea ☐ Anorexia/Bulimia

Current Medications: (Prescription or OTC): _____

Past Surgery: _____

Allergies: *(Food, Medicine, Seasonal)* _____

Date of Last Physical Exam/Pap/Mammogram/etc: _____

General Physician, location: _____

Family History of Illness: *(Maternal or Paternal)* _____

Social History: ☐ Alcohol ☐ Tobacco ☐ Caffeine (Coffee, Tea, Soda) *Other Recreational Uses:* _____

How many hours of sleep do you average per night: _____ How do you sleep? ☐ On Back ☐ On Side ☐ On Stomach

What type of mattress do you sleep on? ☐ Spring ☐ Foam What type of pillow do you use? ☐ Polyester ☐ Foam ☐ Down

Describe your eating habits: ☐ Skip Breakfast ☐ Two Meals a Day ☐ Three Meals a Day ☐ Snack between Meals

Any major stressors in life: _____

Any additional health goals: _____

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

X

_____

Patient Signature or Responsible Representative