SYSTEMS REVIEW

Many Of The Following Issues Respond To Chiropractic And Acupuncture Treatment.
Please Check Each Of The Conditions Below That You Are Currently Experiencing or Have Experienced in the Past.

Date: __________________ **Name:** ____ **Patient #:** ______________

Constitutional
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in This Category*

Musculoskeletal
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems: ________
- ❑ Leg Problems: ________
- ❑ Swollen/Stiff Joints
- ❑ Painful Joints
- ❑ Sore/Weak Muscles
- ❑ Walking Problems
- ❑ Spasms/Cramps
- ❑ Broken Bones: ________
- ❑ Other: _______________
- ❑ *None in This Category*

Endocrine, Hematologic, and Lymphatic
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Excessive Thirst
- ❑ Cold Extremities
- ❑ Heat/Cold Intolerance
- ❑ Change in Hat/Glove Size
- ❑ Dry Skin
- ❑ Glandular/Hormone Problems
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise/Bleed
- ❑ Vein Inflammation
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: ____________
- ❑ *None in This Category*

Neurological
- ❑ Numbness/Tingling
- ❑ Loss of Feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Recurrent Headaches
- ❑ Convulsions/Seizures
- ❑ Stroke
- ❑ Tremors
- ❑ History of Head Injury
- ❑ Other: ____________
- ❑ *None in This Category*

Genitourinary
- ❑ Bladder Trouble
- ❑ Change in Force/Strain when Urinating
- ❑ Frequent Urination
- ❑ Scanty Urination
- ❑ Painful Urination
- ❑ Discolored Urination
- ❑ Incontinence/Bed Wetting
- ❑ Kidney Stones
- ❑ Sexual Difficulty
- ❑ Other: ____________
- ❑ *None in This Category*

Cardiovascular
- ❑ Chest Pains
- ❑ Rapid/Change in Heartbeat
- ❑ Blood Pressure Problems
- ❑ Heart problems
- ❑ Swelling of Hands/Ankles/Feet
- ❑ Other: ____________
- ❑ *None in This Category*

Gastrointestinal
- ❑ Change in Appetite
- ❑ Nausea/Vomiting
- ❑ Abdominal Pain
- ❑ Change in Bowel Movements
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black/Bloody Stool
- ❑ Hemorrhoids
- ❑ Gallbladder Problems
- ❑ Other: ____________
- ❑ *None in This Category*

Skin and Breasts
- ❑ Rash/Itching
- ❑ Change in Skin Color
- ❑ Change in Hair/Nails
- ❑ Non-healing Sores
- ❑ Change in Mole's Appearance
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: ____________
- ❑ *None in This Category*

Ears, Nose, and Throat
- ❑ Bleeding Gums/Mouth Sores
- ❑ Bad Breath/Taste
- ❑ Dental Problems
- ❑ Swollen Throat/Voice Change
- ❑ Swollen Neck Glands
- ❑ Ringing in Ears
- ❑ Ear Ache/Ringing/Drainage
- ❑ Sings/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: ____________
- ❑ *None in This Category*

Mind/Stress
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems/Insomnia
- ❑ Memory Loss/Confusion
- ❑ Other: ____________
- ❑ *None in This Category*

Respiratory
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: ____________
- ❑ *None in This Category*

Eyes and Vision
- ❑ Wear Contacts/Glasses
- ❑ Blurred/Double Vision
- ❑ Glaucoma
- ❑ Eye Disease/Injury
- ❑ Other: ____________
- ❑ *None in This Category*

Women Only

Are you Pregnant?
- ❑ **Yes - *Guess Date:*** ______
  - ***Sex of Baby*:** ______
  - ***OBGYN:*** ______
- ❑ **No**
- ❑ Painful/Irregular Periods
- ❑ Vaginal pain
- ❑ Infertility
- ❑ Other: ____________
- ❑ *None in This Category*

Past Pregnancies

Date	Outcome

Assignment of Benefits and Consent of Professional Services

I hereby authorize Choice Chiropractic & Acupuncture to release all or any part of my medical record to any person or corporation which is or may be liable under a contract to the clinic, patient, relative or employer of the patient to cover all or part of the clinic's charge. I voluntarily agree to assign all applicable payments or benefits appearing in said contract to be paid directly to Choice Chiropractic & Acupuncture. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me and I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of amounts not collected from the insurance company. If collection or legal actions should become necessary to recover debt for services rendered to me by Choice Chiropractic & Acupuncture, I understand that I am personally responsible for all fees incurred to collect said debt. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

- ❑ **I have been made aware of and have access to Choice Chiropractic & Acupuncture's "Notice of Privacy Practices." I understand that I should contact the Privacy Officer or a staff member of Choice Chiropractic & Acupuncture if I have any questions or concerns.**
- ❑ **I hereby authorize Dr. Heather Van Wyhe and her assistants to administer chiropractic care, diagnostic testing, and/or therapeutic services as she deems necessary, in accordance with Oklahoma statutes.**

By signing, I agree that I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient Signature : ____ **Date:** ________________

Witness Signature: ____ **Date:** ________________