Patient systems review   Patient name: _________________ Date: ___/___/___

Spinal problems can cause or contribute to the conditions listed below. Please **check off** any of the symptoms listed that you have noticed either now or in the recent past. If they are *recent*, **circle** the choice as well. –Thank you!

Head and Neck Region

☐headaches/migraine: location ___________________________

☐dizziness/lightheaded
☐visual problems (besides glasses)
☐facial numbness
☐difficulty swallowing
☐tension across shoulders
☐numbness/tingling in arms/hands
☐fingers swollen/tight/sore
☐anxiety
☐sinus/allergy
☐ringing in ears
☐difficulty clearing throat/hoarse
☐metallic taste
☐difficulty using arms overhead
☐cold arms/fingers
☐weight stabilization
☐fatigue

Notes by Dr. ____

____

Mid Back Region

☐mid back pain ______________
☐difficulty breathing
☐asthma
☐chest pressure/pain
☐high blood pressure
☐rib pain
☐shortness of breathe
☐recurrent lung infections
☐heart issues
☐diabetes/hypoglycemia
☐gallbladder/stomach/kidney/liver problems____________________________

Notes by Dr. ____

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Low Back Region

☐pain: low back/hips/knees/legs/ankles/feet   ________________________

☐numbness/tingling in legs/feet
☐cramping in legs/Restless Leg Syn.
☐Irritable Bowel Syndrome
☐frequent urination
☐bladder control issues
☐hormonal problems
☐erectile dysfunction
☐hemorrhoids
☐cold legs/feet
☐constipation/diarrhea
☐excess gassiness/bloating
☐difficulty emptying bladder
☐painful/irregular menstrual cycle
☐fertility issues
☐prostate problems

Notes by Dr. ____

____

Please list any medications you are currently taking:

	RX name	Dr. who prescribed it	for what condition	how long
1.	____________	________________	______________	_______
2.	____________	________________	______________	_______
3.	____________	________________	______________	_______
4.	____________	________________	______________	_______
5.	____________	________________	______________	_______

Others: ____

Did you stop taking any medication you're supposed to be taking? ☐ Yes ☐ No

If so, drug name: ___________________, for what condition? _____________________

Prescribed by what Doctor? ____

Why did you discontinue taking this? ____

Does your Dr. know?☐ Yes ☐ No   **Patient Signature**: _______________________