DIAMOND STATE CHIROPRACTIC, P.A.

Kristina A. Hollstein, D.C., D.A.B.C.O & Gregory J. Serge, D.C., F.I.A.M.A

Today's Date: ____________________ **Who is your Primary Doctor?** ____________________________

Name: ___________________________________ Your health Insurance: __________________________

Review of Systems

Since your last visit has any of the following below changed? ◯ No ◯ Yes (Check below)

Cardiovascular issues? ◯ Aortic Aneurism ◯ Chest Pain ◯ Heart Attack ◯ Heart Disease ◯ High Blood Pressure ◯ High Cholesterol ◯ Vascular Disease ◯ Pace Maker ◯ Blood Clots ◯ Swelling

Genitourinary issues? ◯ Blood in Urine ◯ Painful Urination ◯ Frequent Urination ◯ Kidney Disease ◯ Kidney Stones

Hematologic/lymphatic problems? ◯ Blood clots ◯ Hepatitis ◯ Easy Bleeding/Bruising ◯ Fever/Chills/Sweats

Neurological issues? ◯ Carpal Tunnel ◯ Brain/Head Injury ◯ Numbness ◯ Parkinson's Disease ◯ Seizures ◯ Severe Headaches ◯ Dizziness/Balance ◯ Stroke

Respiratory issues? ◯ Asthma ◯ Sleep Apnea ◯ Emphysema ◯ Shortness of Breath ◯ Pneumonia ◯ Tuberculosis

Head and ENT issues? ◯ Bleeding Gums ◯ Difficulty Swallowing ◯ Dizziness ◯ Hearing ◯ Nose Bleed ◯ Sinus Infection

Eye conditions? ◯ Blurred Vision ◯ Double Vision ◯ Glaucoma ◯ Cataracts

Dermatological issues? ◯ Eczema ◯ Psoriasis ◯ Rashes ◯ Skin Disease ◯ Skin Ulcers

Psychiatric complaints? ◯ Anxiety Disorder ◯ Depression

Endocrine issues? ◯ Diabetes ◯ Hair Loss ◯ Menopausal ◯ Thyroid Disease

Weight changes, weakness, fatigue, or fever? ◯ Fatigue/Weakness ◯ Weight Loss ◯ Weight Gain

Gastrointestinal issues? ◯ Bloody Stools ◯ Bowel Problems ◯ Constipation ◯ Gallbladder ◯ Liver Disease ◯ Nausea/Vomiting ◯ Poor Appetite ◯ Ulcers

Musculoskeletal issues? ◯ Arthritis ◯ Broken Bones ◯ Gout ◯ Joints Replaced ◯ Joint Stiffness/Pain ◯ Muscle Weakness ◯ Osteoporosis

Do you have any personal history of Cancer? ◯ Breast ◯ Lung ◯ Prostate ◯ Thyroid ◯ Skin
Other: ___________________________

Patient's surgical history? ◯ Discectomy ◯ Spinal Fusion ◯ Gallbladder Removed ◯ Hysterectomy ◯ Gastric Bypass ◯ Other: ____

New medication(s)? Any new medications since your last visit? ◯ No ◯ Yes (Name and dose below)
(Dose and Frequency) __________________________________ ______________________________

Do you have any drug allergy? If no allergies, check here: ◯
________________________________ ________________________ _________________________

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Any NEW Immediate Family Health History since your last visit: ◯ **No**

M=Mother **F**=Father **B**=Brother **SO**=Son **S**=Sister **DA**=Daughter

Cancer: ____________ **Type**: __________ **Hypertension**: ______________________________

Dementia/Alz: _____ **Type**: ___________ **Kidney Disease**: ___________ **Type**: ___________

Diabetes: __________ **Type**: ___________ **Lung Disease**: ____________ **Type**: ___________

Heart Disease: ______**Type**: ___________ **Osteoporosis**: ____________ **Type**: ___________

High Cholesterol: _____________________ **Stroke/Brain**: ____________ **Type**: ____________

Social habits? ◯ Does not smoke, drink alcohol, or take rec. drugs.
◯ Is a social drinker ◯ Current every day smoker ◯ Former Smoker ◯ Never Smoked

Have you received any past care for this complaint? ◯ No ◯ Yes
If yes where and when: ____

Patient height?___________ **Patients Weight?** _________?

Describe your current problem?

When did your symptoms begin? (Must be within the past 30 days for Acute) ____/____/_____

What caused your symptoms? (Ex: Lawn/gardening, Lifting, Slept wrong) ___________________________

How often do you experience your symptoms?

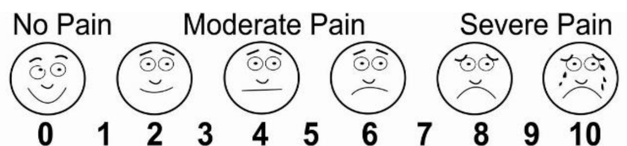
◯ Constantly (76-100% of the day) ◯ Frequently (51-75% of the day) ◯ Occasionally (26-50% of the day) ◯ Intermittently (0-25% of the day)

List your main problem: ____________________________ **Pain #** _______________ (On your worst day)

Other problems:

2.) _____________ Pain # _________ (On your worst day)

3.) _____________ Pain # _________ (On your worst day)



What aggravates your pain? ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Lifting ◯ Sleeping ◯ Straining ◯ Reaching ◯ Looking up ◯ Looking down ◯ Movement ◯ Driving ◯ House Chores ◯ Exercise ◯ Stairs ◯ Laying Supine ◯ Laying Prone

What relieves it? ◯ Sitting ◯ Standing ◯ Lying ◯ Knees bent up ◯ Support ◯ No movement ◯ Heat ◯ Ice ◯ Ibuprofen ◯ Medication ◯ Rest ◯ Stretching/Exercise ◯ Adjustment

Does your pain radiate down? ◯ Right Arm ◯ Left Arm ◯ Both Arms ◯ R Leg ◯ L Leg ◯ Both Legs

Who have you seen for your symptoms? ◯ No one ◯ MD ◯ Phys Therapy ◯ Other: ______________

What treatment did you receive for your symptoms? ◯ Physical Therapy ◯ Medicine ◯ Surgery/Injection

____

When did you receive this treatment? ◯ In Last 30 days ◯ Less than 1 year ago ◯ 1-5 years ago

What test have you had for your symptoms? ◯ X-Ray ◯ MRI ◯ CT ◯ Other: ____________________

Where did you have your imaging done at? ____

When were these tests done? ◯ In the last month ◯ Less than 1 year ◯ 5 years ago ◯ 5 + years ago