Chiropractic Center of New Britain
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REVIEW OF SYSTEMS FORM

Patient Name: _____ *Date:* _____

❖ Please **CIRCLE** the box stating *None* if it applies

Have you had any of the following *pulmonary (lung-related)* issues? ***None***

☐Asthma / Difficulty breathing ☐ COPD ☐Emphysema
☐Other:

Have you had any of the following *cardiovascular (heart-related)* issues or procedures? ***None***

☐Heart surgeries ☐Congestive Heart Failure ☐Pacemaker ☐Heart Attack / MI's ☐Heart Disease / Problems
☐Hypertension ☐Murmurs / Valvular Disease ☐Angina / Chest Pain ☐Irregular Heartbeat
☐Other:

Have you had any of the following *endocrine (glandular/hormonal-related)* issues or procedures? ***None***

☐Thyroid Disease ☐Hormone Replacement Therapy ☐Injectable Hormone Replacements ☐Diabetes
☐Other:
☐

Have you had any of the following *renal (kidney-related)* issues or procedures? ***None***

☐Renal Calculi / Stones ☐Hematuria (blood in urine) ☐Incontinence (can't control) ☐Bladder Infections ☐Difficulty Urinating
☐Kidney Disease ☐Dialysis
☐Other:

Have you had any of the following *gastroenterological (stomach-related)* issues? ***None***

☐Nausea ☐Difficulty Swallowing ☐Ulcerative Disease ☐Frequent Abdominal pain ☐Hiatal Hernia
☐Constipation ☐Pancreatic Disease ☐Irritable Bowel/Colitis ☐Hepatitis or Liver Disease ☐Bloody or Black Tarry Stools
☐Vomiting Blood ☐Bowel incontinence ☐Gastroesophageal Reflux/Heartburn
☐Other:

Have you had any of the following *hematologic (blood-related)* issues? ***None***

☐Regular Anti-Inflammatory use (*Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve*)
☐Hypercoagulation or Deep Venous Thrombosis/History of Blood Clots
☐Anemia ☐HIV Positive ☐Abnormal Bleeding/Bruising ☐Sickle-Cell Anemia ☐Enlarged Lymph Nodes
☐Hemophilia ☐Anticoagulant Therapy ☐Regular Aspirin Use
☐Other:

Have you had any of the following *dermatologic (skin-related)* issues? ***None***

☐Significant Burns ☐Significant Rashes ☐Skin Grafts ☐Psoriatic Disorders
☐Other:

Have you had any of the following *musculoskeletal (bone/muscle-related)* issues? ***None***

☐Rheumatoid Arthritis ☐Gout ☐Osteoarthritis ☐Broken Bones ☐Spinal Fracture
☐Spinal Surgery ☐Joint Surgery ☐Arthritis (unknown type) ☐Scoliosis ☐Metal Implants
☐Other:

Have you had any of the following *psychological* issues? ***None***

☐Psychiatric Diagnosis ☐Depression ☐Suicidal Ideations ☐Bipolar Disorder
☐Psychiatric Hospitalizations ☐Schizophrenia ☐Homicidal Ideations
☐Other:

Is there anything else in your medical history that you feel is important to your care here? _____

I have read the above information and certify that it is to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with Chiropractic Care in accordance with the state statutes.
Patient or Guardian Signature: _____