

Review of Systems (Mark off any conditions that you have had or are currently experiencing)

(for office use)

Pain in	<input type="checkbox"/> Neck <input type="checkbox"/> Upper Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Shoulders <input type="checkbox"/> Elbows <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Knees <input type="checkbox"/> Feet <input type="checkbox"/> None
Musculoskeletal	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> None
Neurological	<input type="checkbox"/> Headache <input type="checkbox"/> Pins and Needles <input type="checkbox"/> Numbness <input type="checkbox"/> None
Cardiovascular	<input type="checkbox"/> High or Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Angina <input type="checkbox"/> Excessive Bruising <input type="checkbox"/> None
Respiratory	<input type="checkbox"/> Asthma <input type="checkbox"/> Apnea <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> None
Digestive	<input type="checkbox"/> Anorexia/Bulimia <input type="checkbox"/> Ulcer <input type="checkbox"/> Food Sensitivities <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> None
Sensory	<input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Ear Infections <input type="checkbox"/> Smell <input type="checkbox"/> Taste <input type="checkbox"/> None
Skin	<input type="checkbox"/> Skin Cancer <input type="checkbox"/> Psoriasis/Eczema <input type="checkbox"/> Acne <input type="checkbox"/> Rash <input type="checkbox"/> None
Endocrine	<input type="checkbox"/> Thyroid Issues <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Frequent Infection <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Low Energy <input type="checkbox"/> None
Genitourinary	<input type="checkbox"/> Kidney Issues <input type="checkbox"/> Infertility <input type="checkbox"/> Bedwetting <input type="checkbox"/> Prostate Issues <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> None
Constitutional	<input type="checkbox"/> Fainting <input type="checkbox"/> Low Libido <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden Weight Gain/Loss <input type="checkbox"/> Weakness <input type="checkbox"/> None

Patient Name _____

Patient Number _____

Personal History (Please provide a complete account of past medical history)

Past and current illnesses or conditions including childhood illnesses: _____

Allergies: _____

Operations and Surgeries: _____

Treatments: _____

Injuries, Broken Bones, Accidents: _____

Family History (Please provide details on known family medical history)

Relative	Age(Living)	Illness	Age at Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Brother	_____	_____	_____	_____

Social History (Please provide details about your social history)

Include type, daily/weekly use, and how much consumed or used

Alcohol: _____

Coffee: _____

Tobacco: _____

Pain Relievers: _____

How does your condition affect or limit your abilities in your daily life? Such as: hobbies, work, standing, sitting, driving, sleeping, interactions with others

Doctors Initials _____

On-Site Chiropractic

Page 2/3

		(for office use)
Initials	Policy/Acknowledgments	Patient Name
_____	Payment is expected in full on every visit. On-Site Chiropractic accepts payment preferably by exact cash, but also accepts credit/debit card, mobile payment apps and Health Savings Accounts(HSA).	Patient Number
_____	On-Site Chiropractic does not accept medical insurance, Medicare, Medicaid, Work Comp, or Personal Injury cases. The patient is responsible for payment of all services.	
_____	Upon request, documentation can be provided to the patient for their own personal submission to insurance.	
_____	I grant permission to On-Site Chiropractic to contact me to schedule, reschedule, or confirm appointments via: (check all the apply) <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message <input type="checkbox"/> Email	
_____	I grant permission to On-Site Chiropractic to contact me with promotional and marketing information related to the practice via: (check all the apply) <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message <input type="checkbox"/> Email <input type="checkbox"/> Postal Service	
_____	I acknowledge that On-Site Chiropractic's Notice of Privacy Practices of Protected Health Information is viewable at www.theonsitechiro.com and details how they use or disclose my personal health information.	Doctors Initials
		On-Site Chiropractic
		Page 3/3

Patient Signature _____ Date _____

Guardian Name _____ Relationship _____
 (If patient is under the age of 18 years old)

Guardian Signature _____ Date _____
 (If patient is under the age of 18 years old)