



DATE: \_\_\_\_\_  
 ACCT: \_\_\_\_\_  
 PATIENT: \_\_\_\_\_

## SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

	<b>FOR DOCTORS'S USE ONLY</b>	
	DR. REVIEWED	SYSTEMS SYMPTOMS
High Blood Pressure _____	_____	General Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity
Dizziness/Fainting _____	_____	Skin Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
Insomnia _____	_____	Head Trauma, headaches, dizziness, light headed
Low Resistance _____	_____	Eyes Change in acuity of vision, use of corrective lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
Tension _____	_____	Nose Rhinorrhea, epistaxis, allergies, airway obstruction
Confusion _____	_____	Mouth & Throat Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
Fatigue _____	_____	Neck Stiffness, lumps/swelling/masses, pain
Ulcers _____	_____	Lungs Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
Eye/Vision Problems _____	_____	Cardiac Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
Ear/Hearing Problems _____	_____	Vascular Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
Difficulty Breathing _____	_____	Breasts Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
Heart Problems _____	_____	Gastrointestinal Unusal diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling
Loss of Bladder Control _____	_____	Genitourinary Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematuria, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
Constipation _____	_____	Endocrine Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
Diarrhea _____	_____	Hematopoietic Anemia, abdominal bleeding, lymph node enlargement/pain
Digestion Problems _____	_____	Musculoskeletal Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
Nausea _____	_____	Neurological Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia
Female Problems _____	_____	Psychological Mood swings, depression, anxiety, phobias
Prostate Problems _____		
Diabetes _____		
Hands/Feet Cold _____		
Hand Tremors _____		
Loss of Memory _____		
Nervousness _____		
Sweaty Palms _____		
Speech Difficulty _____		
Anxiety _____		
Depression _____		
Irritability _____		

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

**FOR DOCTORS USE ONLY**

- Reviewed External    H   P
- Release Records       H   P
- Request Records        H   P

### PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

EXTERNAL Dx'D: \_\_\_\_\_

DISABILITIES: \_\_\_\_\_

IMPAIRMENTS: \_\_\_\_\_

DATE: \_\_\_\_\_  
 ACCT: \_\_\_\_\_  
 PATIENT: \_\_\_\_\_

**PATIENT HISTORY**

1. What is your **main complaint**? \_\_\_\_\_  
 2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

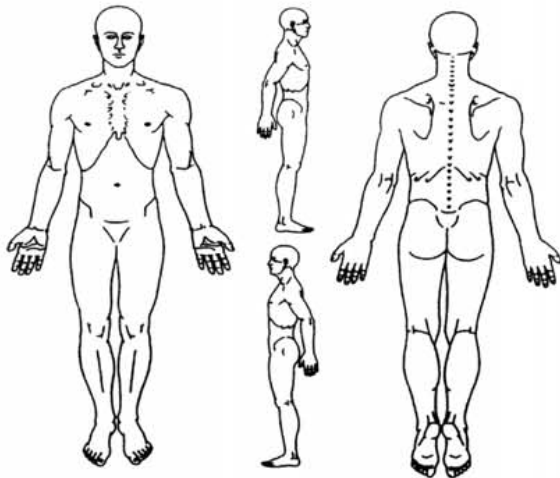
None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			Intermittent			Frequent			Constant		
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint**? \_\_\_\_\_  
 5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

**A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care	_____
lifting	_____
reading	_____
concentrating	_____
work	_____
driving	_____
sleeping	_____
recreation	_____
walking	_____
sitting	_____
standing	_____
social life	_____

6. When do you notice it most?  AM  PM  
 How long does it last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs  
 7. What makes it feel better? \_\_\_\_\_  
 8. What makes it feel worse? \_\_\_\_\_  
 9. Have you ever had this problem in the past?  Yes  No  
 10. I have  been hospitalized  been treated by another chiropractor  
 been treated by another specialty provider  never received care for this problem.  
 11. Have you lost time from work because of it?  Yes  No  
 Dates? \_\_\_\_\_ to \_\_\_\_\_  
 12. Are you Pregnant?  Yes  No  
 13. What was the first day of your last menstrual cycle? \_\_\_\_\_  
 14. Number of pregnancies? \_\_\_\_\_ Miscarriages? \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_



***Grant Chiropractic Life Center, P. C.  
2510 W. Chandler Blvd., Suite #3  
Chandler, AZ 85224***

I, \_\_\_\_\_, authorize the performance upon myself of the following procedures: Chiropractic manipulation, hot/cold packs, electrical muscle stimulation, exercise therapy, stretching, spinal traction, massage, infrared, nutritional advice and prescription to be performed by or under Daniel Grant, D.C.'s supervision, or his designated employees, as clinically indicated.

I consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that Dr. Grant may consider necessary or advisable in the course of my health care.

Dr. Grant and/ or his associates and assistants have explained the nature and purpose of the procedures, possible alternatives, the risks involved, the possible alternatives, the risks involved, the possible consequence, and the possibility of complications to me.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, please inform Dr. Grant or his staff and other accommodations will be made for you.

I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by Dr. Grant, his associates and assistants.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness: \_\_\_\_\_ Relationship: \_\_\_\_\_



**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

If you are a minor, or if you are being represented by another party:

\_\_\_\_\_  
Personal Rep (Print)

\_\_\_\_\_  
Personal Rep (Signature)

\_\_\_\_\_  
Description of the authority to act on behalf of the patient

\_\_\_\_\_  
Date

The patient named below has chosen not to sign the Privacy Practices Acknowledgement. This does not affect the type of treatment or quality of care the patient will receive in our office. We have attempted, to the best of our ability, to provide this patient with a copy of our Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Employee

\_\_\_\_\_  
Title