



# Brenham Chiropractic Clinic

Systems Review *Please select any symptoms that the patient currently has:*

## Genito-Urinary System

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Back pain       | <input type="checkbox"/> Cloudy urine     | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Scanty urination     |
| <input type="checkbox"/> Bed wetting     | <input type="checkbox"/> Discharge        | <input type="checkbox"/> Impotence           | <input type="checkbox"/> Small caliber stream |
| <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Discolored urine | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Stones               |
| <input type="checkbox"/> Burning         | <input type="checkbox"/> Dribbling        | <input type="checkbox"/> Painful urination   | <input type="checkbox"/> Straining            |
| <input type="checkbox"/> Urgency         |   |  |   |

## Nervous System

- |   |   |   |                                    |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Confusion            | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Loss of feeling    | <input type="checkbox"/> Tingling  |
| <input type="checkbox"/> Convulsions          | <input type="checkbox"/> Forgetfulness  | <input type="checkbox"/> Loss of memory     | <input type="checkbox"/> Vertigo   |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Hand trembling | <input type="checkbox"/> Muscle jerking     | <input type="checkbox"/> Weak grip |
| <input type="checkbox"/> Difficulty of speech | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Numbness paralysis |                                    |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Incoordination | <input type="checkbox"/> Seizures           |                                    |

## Eyes, Ears, Nose & Throat

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Lack of smell      | <input type="checkbox"/> Ear discharge           | <input type="checkbox"/> Loss of teeth        | <input type="checkbox"/> Sore throat       |
| <input type="checkbox"/> Bleeding gums      | <input type="checkbox"/> Ear noises              | <input type="checkbox"/> Nose bleeding        | <input type="checkbox"/> Sores             |
| <input type="checkbox"/> Blisters           | <input type="checkbox"/> Ear pain                | <input type="checkbox"/> Nasal discharge      | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Eye inflammation        | <input type="checkbox"/> Nose pain            | <input type="checkbox"/> Tonsillitis       |
| <input type="checkbox"/> Dental problems    | <input type="checkbox"/> Eye strain              | <input type="checkbox"/> Pain                 | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Deviated septum    | <input type="checkbox"/> Halitosis               | <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Vision problems   |
| <input type="checkbox"/> Dry mouth          | <input type="checkbox"/> Hearing loss hoarseness | <input type="checkbox"/> Sore gums            |  |
| <input type="checkbox"/> Dysphagia          | <input type="checkbox"/> Loss of smell           | <input type="checkbox"/> Sore mouth           |  |

## Gastro-Intestinal System

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Abnormal pain | <input type="checkbox"/> Difficulty chewing    | <input type="checkbox"/> Hemorrhoids   | <input type="checkbox"/> Vomiting blood          |
| <input type="checkbox"/> Black stool   | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Weight loss over 10 lbs |
| <input type="checkbox"/> Bloody stool  | <input type="checkbox"/> Excessive hunger      | <input type="checkbox"/> Nausea        |  |
| <input type="checkbox"/> Constipation  | <input type="checkbox"/> Excessive thirst      | <input type="checkbox"/> Poor appetite |  |
| <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Gall bladder          | <input type="checkbox"/> Vomiting food |  |

## Cardiovascular

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Coughing blood       | <input type="checkbox"/> Heart problem   | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Coughing phlegm      | <input type="checkbox"/> Lung problem    | <input type="checkbox"/> Rapid heartbeat  |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Varicose veins   |

## Constitutional

- |   |                                       |   |                                   |
|---|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Irritability loss of sleep | <input type="checkbox"/> Tension  |
| <input type="checkbox"/> Chills             | <input type="checkbox"/> Fainting     | <input type="checkbox"/> Memory loss                | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Concentration loss | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Nervousness                |                                   |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Fever        | <input type="checkbox"/> Night sweats               |                                   |

## Integumentary

- |                                      |                                  |   |                                |
|--------------------------------------|----------------------------------|---|--------------------------------|
| <input type="checkbox"/> Dryness     | <input type="checkbox"/> Itching | <input type="checkbox"/> Nail bed changes | <input type="checkbox"/> Sores |
| <input type="checkbox"/> Hair change | <input type="checkbox"/> Moles   | <input type="checkbox"/> Rashes           |                                |

## Musculoskeletal

- |                                     |  |   |  |
|-------------------------------------|--|---|--|
| <input type="checkbox"/> Back pain  | <input type="checkbox"/> Joint pain      | <input type="checkbox"/> Muscle cramps    | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Hot joints | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Muscle pain      | <input type="checkbox"/> Spine curvature |
| <input type="checkbox"/> Injuries   | <input type="checkbox"/> Joint swelling  | <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> Tenderness      |

## Endocrine

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Breast changes   | <input type="checkbox"/> Extreme thinness | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Hair changes     | <input type="checkbox"/> Hoarseness       | <input type="checkbox"/> Weight loss |

## Psychiatric

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Drug dependency  | <input type="checkbox"/> Insecurity      | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Anxiousness    | <input type="checkbox"/> Extreme worry    | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Timid             |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Hallucinations   | <input type="checkbox"/> Loss of memory  | <input type="checkbox"/> Troubled sleep    |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Undecidedness     |

[NP Forms 8/05]

Name:

Case #

Date