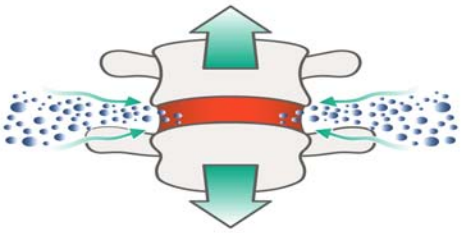

CROSS
SPINE & DISC
NON-SURGICAL SOLUTIONS

PATIENT HISTORY/REVIEW OF SYSTEMS

Name: _____ Date: _____

Please tell us if YOU or a member of YOUR IMMEDIATE FAMILY have had any of the following:

		Individual		Family Member	
1	Back Pain/Leg Pain	Yes	No	Yes	No
2	Neck Pain/Arm Pain	Yes	No	Yes	No
3	Cancer	Yes	No	Yes	No
4	Diabetes	Yes	No	Yes	No
5	Neurological Disease/Headaches/Seizures	Yes	No	Yes	No
6	Heart/Circulatory Problems	Yes	No	Yes	No
7	High Blood Pressure	Yes	No	Yes	No
8	Stomach or Bowell Problems	Yes	No	Yes	No
9	Broken Bones	Yes	No	Yes	No
10	Skin Disease	Yes	No	Yes	No
11	Prostate Disease/Hormone Therapy	Yes	No	Yes	No
12	Depression, Anxiety, etc.	Yes	No	Yes	No
13	Painful or Irregular menstrual Cycles	Yes	No	Yes	No
14	Tendonitis	Yes	No	Yes	No
15	Exercise on a regular basis	Yes	No	Yes	No
16	Motor Vehicle Accident or Other Injuries	Yes	No	Yes	No
17	Alcohol/Nicotine	Yes	No	Yes	No
18	Nicotine	Yes	No	Yes	No
19	Allergies/Upper respiratory infection/flu/cough	Yes	No	Yes	No
20	Surgeries	Yes	No	Yes	No
21	Chiropractic Treatment Before	Yes	No	Yes	No
22	Unintended weight gain/loss	Yes	No	Yes	No
23	Recent International Travel	Yes	No	Yes	No

Please explain any “Yes” answers: _____