

Patient Name _____

Date _____

REVIEW OF SYSTEMS**Instructions:** Please mark ALL you have repetitively suffered with NOW or in the PAST

VERTEBRAL LEVEL	Area Controlled	Possible Effects of Malfunction
	Blood supply to the head, pituitary gland, scalp, bones, of the face, brain, inner and middle ear, sympathetic nervous system	<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Colds <input type="checkbox"/> HBP <input type="checkbox"/> Chronic Tiredness <input type="checkbox"/> Amnesia <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Nervousness <input type="checkbox"/> Insomnia
	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead	<input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Allergies <input type="checkbox"/> Pain around eyes <input type="checkbox"/> Earaches <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Fainting <input type="checkbox"/> Deafness <input type="checkbox"/> Blindness (some)
	Cheeks, outer ear, face bones, teeth, tri-facial nerve	<input type="checkbox"/> Neuralgia <input type="checkbox"/> Neuritis <input type="checkbox"/> Acne/Pimples <input type="checkbox"/> Eczema <input type="checkbox"/> Neck Pain, Stiffness, Soreness
	Nose, lips, mouth, Eustachian tube	<input type="checkbox"/> Hay Fever <input type="checkbox"/> Runny Nose <input type="checkbox"/> Swollen Adnoids
	Vocal Cords, Neck glands, pharynx	<input type="checkbox"/> Laryngitis <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hand Numbness <input type="checkbox"/> Sore throats <input type="checkbox"/> Tonsillitis
	Neck Muscles, shoulders, tonsils	<input type="checkbox"/> Stiff neck <input type="checkbox"/> Upper arm Pain <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Croup <input type="checkbox"/> Hand Numbness <input type="checkbox"/> Shoulder Pain
	Thyroid glands, bursae in the shoulders, elbows	<input type="checkbox"/> Bursitis <input type="checkbox"/> Colds <input type="checkbox"/> Thyroid conditions <input type="checkbox"/> Wrist/Hand Numbness
	Elbow down, including hands, wrists, and fingers, esophagus and trachea	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Pain into Arms or hands <input type="checkbox"/> Shortness of breath
	Heart, including its valves and covering, coronary arteries	<input type="checkbox"/> Heart Problems <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure
	Lungs, bronchial tubes, pleura, chest, breast	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Congestion <input type="checkbox"/> Influenza <input type="checkbox"/> Mid Back Pain, burning, stiffness
	Gallbladder, common duct	<input type="checkbox"/> Gallbladder conditions <input type="checkbox"/> Jaundice <input type="checkbox"/> Shingles
	Liver, solar plexus, circulation-general	<input type="checkbox"/> Liver conditions <input type="checkbox"/> Fevers <input type="checkbox"/> Arthritis <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Other Blood Pressure Problems
	Stomach	<input type="checkbox"/> Stomach troubles <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Heartburn <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Nervous Stomach
	Pancreas, duodenum	<input type="checkbox"/> Ulcers <input type="checkbox"/> Gastritis <input type="checkbox"/> Mid Back Pain or burning
	Spleen	<input type="checkbox"/> Lowered Immune System
	Adrenal and Suprarenal glands	<input type="checkbox"/> Allergies <input type="checkbox"/> Hives <input type="checkbox"/> Mid Back Soreness
	Kidneys	<input type="checkbox"/> Kidney Problems <input type="checkbox"/> Hardening of Arteries <input type="checkbox"/> Chronic Tiredness <input type="checkbox"/> Back Pain <input type="checkbox"/> Nephritis
	Kidneys, ureters	<input type="checkbox"/> Skin Conditions <input type="checkbox"/> Pimples <input type="checkbox"/> Boils <input type="checkbox"/> Acne <input type="checkbox"/> Eczema
	Small Intestines, lymph circulation	<input type="checkbox"/> Rheumatism <input type="checkbox"/> Gas Pains <input type="checkbox"/> Certain Sterility
	Large Intestines, inguinal rings	<input type="checkbox"/> Constipation <input type="checkbox"/> Colitis <input type="checkbox"/> Dysentery <input type="checkbox"/> Back Pain <input type="checkbox"/> Some hernias <input type="checkbox"/> Diarrea
	Appendix, abdomen, upper leg	<input type="checkbox"/> Cramps <input type="checkbox"/> Minor Varicose Veins
	Sex organs, uterus, bladder, knees	<input type="checkbox"/> Bladder Problem <input type="checkbox"/> Painful/Irregular Periods <input type="checkbox"/> Miscarriages <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Impotency <input type="checkbox"/> Change of Life symptoms <input type="checkbox"/> Knee Pains
	Prostate gland, Lower back muscles, sciatic nerve	<input type="checkbox"/> Sciatica <input type="checkbox"/> Painful/Frequent Urination <input type="checkbox"/> Backaches <input type="checkbox"/> Pain/Numbness in legs
	Lower legs, ankles, feet	<input type="checkbox"/> Weak or Swollen ankles/arches <input type="checkbox"/> Cold feet <input type="checkbox"/> Plantar fasciitis <input type="checkbox"/> Foot Pain <input type="checkbox"/> Weakness in legs <input type="checkbox"/> Leg cramps <input type="checkbox"/> Heel spurs <input type="checkbox"/> Poor Circulation-leg

Review of Systems: Musculoskeletal Neurological Constitutional Eyes ENMT Cardiovascular
 Respiratory GastroIntestinal Integumentary Psychiatric Endocrine Hematological Immunological