



ARCHER FAMILY WELLNESS CLINIC

Dr. Donna M. Archer
Chiropractic Physician

5512 NE 109th Court,
Suite A
Vancouver, WA 98662

Phone: 360-885-4715
Fax: 360-859-3741
E-mail:
Dr. DonnaArcher@comcast.net
Web:
ArcherFamilyWellness.com

Patient's Name: _____ Date: _____

ROS:

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you?

Please use the following code: **N** – Now **R**—Recent (within past yr.) **P**—Past (> 1 yr. ago)

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart Problems/Stroke |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Back pain or stiffness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shoulder/Neck/Arm Pains | <input type="checkbox"/> Marked Morning Pain & Stiffness |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Pain unrelieved by position or rest |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Indigestion/Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> () Menstrual/Prostate Problems | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Pins & Needles in Arms/Legs | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Numbness in Fingers/Toes | <input type="checkbox"/> Swelling Joints |
| <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Weakness in Arms/Legs | |
| <input type="checkbox"/> Numbness in groin/buttocks | |

Other health care conditions / concerns: (Please list):



PLEASE LIST ALL MEDICATIONS & SUPPLEMENTS YOU ARE TAKING

Patient's Signature: _____ Date: _____

Focus on wellness with chiropractic.