

Required for Your Case History File: All Information Is Confidential

Full Legal Name _____ Name you prefer _____

Mailing Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ Telephone (Work) _____

Email _____ Referred by _____

Occupation _____ Employer _____

Name of Spouse _____ Number of Children _____

Emergency Contact _____ Telephone _____

Age _____ Date of Birth _____ Sex _____ Years of Education _____

Circle one: Married Single Widowed Divorced Separated

Past chiropractic care? Yes No If yes, who? _____

Who is your primary care physician? _____

Date of Last Physical Examination _____

Have you been treated for any health condition by a physician in the last year? Yes No

What medications/vitamins/herbs are you taking? _____

_____ Are you allergic to any medications? Yes No

Previous serious illness/ hospitalization: (Please date & describe) _____

Have ever had: Surgery Yes No Fractures Yes No Car Accidents Yes No
Falls Yes No On-Job Injury Yes No

Family history of: Heart disease Yes No Cancer Yes No Diabetes Yes No

If you are female, are you possibly pregnant? Yes No Date of last menstrual period _____

Primary Symptom/Problem for this visit _____

Have you been prescribed an opioid for your primary problem? Yes No

Have you had a previous surgery for your primary problem? Yes No

Are you considering surgery for your primary problem? Yes No

Have you had a previous steroid injection for your primary problem? Yes No

Are you considering a steroid injection for your primary problem? Yes No

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant Intermittent Is your condition getting? Worse Better Same

What activities aggravate your condition? _____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? Yes No sleep? Yes No routine? Yes No

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional

- ___ Unexplained Weight Loss
- ___ Fatigue or Weakness
- ___ Fever

Eyes

- ___ Glaucoma
- ___ Cataracts
- ___ Double Vision

Ears, Nose, Throat

- ___ Difficulty Hearing
- ___ Buzzing or Ringing in Ears
- ___ Dizziness
- ___ Loss of Smell
- ___ Sinus Trouble
- ___ Difficulty Swallowing
- ___ Loss of Taste

Skin

- ___ Rashes
- ___ Hives
- ___ Itching

Allergic/Immunologic

- ___ Hives/Hay Fever

Respiratory

- ___ Cold/Flu/Cough
- ___ Coughing Blood
- ___ Wheezing

Gastrointestinal

- ___ Nausea or Vomiting
- ___ Constipation
- ___ Diarrhea
- ___ Digestive Problems

Genitourinary

- ___ Blood in Urine
- ___ Bladder Leakage
- ___ Burning/Frequent Urination

Musculoskeletal

- ___ Spinal Pain
- ___ Joint Swelling
- ___ Joint Stiffness

Cardiovascular

- ___ Chest Pain
- ___ Shortness of Breath
- ___ Racing Heartbeat
- ___ Fainting Spells

Neurological

- ___ Headaches
- ___ Memory Loss
- ___ Tremors
- ___ Numbness

- ___ Loss of Strength

- ___ Seizures

Mental Status

- ___ Anxiety/Depression
- ___ Mood Swings
- ___ Difficult Sleeping
- ___ Stress

Endocrine

- ___ Loss of Hair
- ___ Heat/Cold Intolerance
- ___ Diabetes
- ___ Excessive Sweating
- ___ Change in Appetite

Hematologic/Lymphatic

- ___ Ease of bruising
- ___ Gums Bleed Easily
- ___ Enlarged Glands

Check if you have had any of the following symptoms in the last 30 days:

- Pain worse at night Constant pain unrelated to motion Unexplained weight loss
- Loss of bowel or bladder control Bacterial infection Surgery Fever or chills

Check if you have ever had any of the following:

- History of Cancer History of HIV Use of Steroids Use of IV Drugs Blood Transfusions

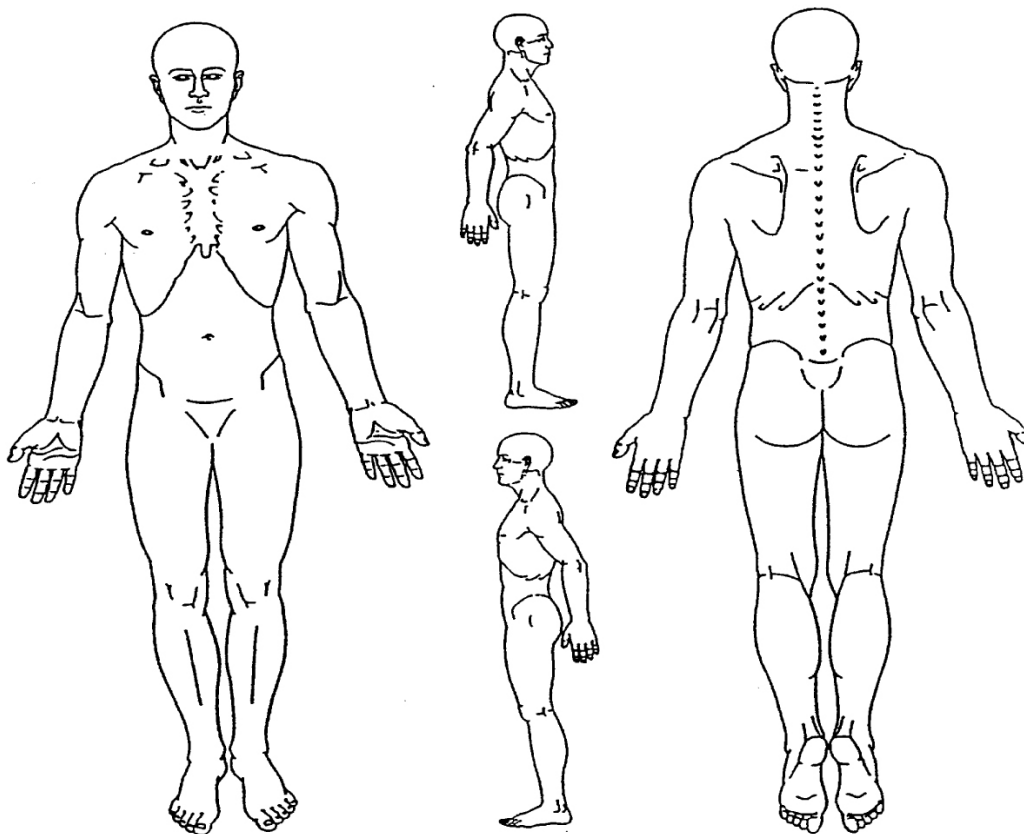
*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

Signature _____ Date _____ form 105 a

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols. Please mark an X on the area where the pain is now worst.

Aching Numbness Pins and Needles Burning Sharp/stabbing Stiff/tight
 yyyyy === oooo zzzz ///// ***



How bad is your pain? On the scale below circle your pain.

Right now..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

On average..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

At its very worst... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Overall, is your pain generally: improving same worsening

Name _____ Date _____

Lifestyle

It is important that we understand your general lifestyle. Please check mark the one choice which **most closely** describes your general lifestyle for each question.

1. Smoking. (For cigars, pipes, or chewing tobacco estimate the amount of tobacco used.)

- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| I do not smoke | I smoke 1/4 pack or less per day | I smoke 1/2 pack per day | I smoke 3/4 pack per day | I smoke 1 pack or more per day |

2. Seat Belts.

- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| I always use seat belts | I use seat belts most of the time | I use seat belts some of the time | I use seat belts a little of the time | I never use seat belts |

3. Exercise. (For this question, exercise means at least 30 minutes of continual activity.)

- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| I exercise 3 to 5 days/week | I exercise 2 days/week | I exercise 1 day/week | I exercise 1 day/month | I am not exercising |

4. Diet. (Fruits and Vegetables are abbreviated as F & V.)

- | | | | | |
|---|---------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| I eat 5 or more servings of F & V per day | I eat 3 servings of F & V per day | I eat 1 serving of F & V per day | I eat 1 to 4 serving of F & V per week | I eat no servings of F & V per week |

5. On average, how many alcohol drinks do you consume per week? (one drink = 12-oz. of beer, 4-oz. of wine, 1 wine cooler, 1 cocktail, or 1 shot of hard liquor)

- | | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| None | 1 drink per week | 2 to 7 drinks per week | 8 to 14 drinks per week | 15 to 21 drinks per week | 22 or more drinks per week |

6. In general, how would you rate your health?

- excellent very good good fair poor

Patient's Signature _____ Date _____

Screening Questionnaire

Please read and answer each item carefully. Circle only one answer for each item.

1. When I am in pain I feel I can't stand it anymore.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

2. When I am in pain it is awful and I feel that it overwhelms me.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

3. When I am in pain I become afraid that the pain will get worse.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

4. When I am in pain I wonder whether something serious may happen.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

5. When I am in pain I keep thinking about how much it hurts.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

6. When I am in pain I can't seem to keep it out of my mind.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

7. In general, how satisfied are you with your job?

0	1	2	3	4
completely satisfied	satisfied	neither satisfied or dissatisfied	dissatisfied	completely dissatisfied

8. During the past month:

Have you often been bothered by feeling down, depressed, or hopeless? Yes No

Have you often been bothered by little interest or pleasure in doing things? Yes No

9. Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Patient's Signature _____ Date _____

