BAUMBICK CHIROPRACTIC CENTER

CASE # _____

DATE _____

PERSONAL HISTORY

NAME _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS # _____

DATE OF BIRTH _____ AGE ____ M ____ F ____ MARITAL STATUS _____ AGES OF YOUR CHILDREN _____

EMPLOYER'S NAME AND ADDRESS _____ OCCUPATION _____ YEARS _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____ Policy No. _____

Are you a member of an H.M.O.? _____ Additional Insurance Self/Spouse Policy No. _____

If retired, state company name that you are retired from, which your Group Health Insurance is with _____

SPOUSE'S NAME _____ EMPLOYER'S NAME & ADDRESS _____

DATE OF BIRTH _____ SS# _____ OCCUPATION _____ WORK PHONE _____

Are you covered under spouse/parents insurance? _____ If yes, with what companies? _____ Policy No. _____

How did you find out about us? ☐ Newspaper ☐ Flyer ☐ Yellow Pages ☐ TV ☐ Radio ☐ Friend _____ ☐ Other

Person to call in an emergency _____ Phone # _____ Relationship _____

Have you ever been a patient here before? _____ When? _____ For What Problem/s _____

PRESENT COMPLAINT IS DUE TO: CHECK (1) OR MORE OF THE FOLLOWING

☐ ON THE JOB INJURY (Use WC Form)	☐ AUTO ACCIDENT (Use AUTO Form)	☐ ILLNESS
☐ HOME INJURY (Use Form)	☐ ACCIDENT NOT IN HOME	☐ DISEASE
☐ ATHLETIC INJURY	☐ SOMEONE ELSE'S NEGLIGENCE	☐ OLD INJURY
☐ SCHOOL SUPERVISED SPORT	☐ POOR PHYSICAL CONDITION	☐ OTHER (EXPLAIN)

WORK RELATED INJURY: (WORKMAN'S COMPENSATION) ADDITIONAL FORMS REQUIRED

Is problem result of work injury? _____ New _____ Old _____ Date _____

How problem happened? _____

Have you had this problem before the work injury? _____

If yes, has it become worse since this injury? _____

Did you notify employer of injury? _____ Was accident form made? _____

Was authorization given for your visit? _____ By whom? _____

Phone number of individual giving authorization _____

AUTO ACCIDENT/PERSONAL INJURY: ADDITIONAL FORMS REQUIRED

Is problem result of automobile or motorcycle accident? _____ Other? _____

Brief detail of accident _____

Is accident the sole cause of your pain? _____ Have you had same symptoms before? _____

If you have had before, are symptoms worse since accident? _____

Were police notified? _____ Was a police report made? _____ Did you go to hospital? _____

Remarks: _____

PAST AND PRESENT GENERAL HISTORY

GENERAL SYMPTOMS

Now Have / Have Had

___ ___ Alcoholism (303.9)
___ ___ Anemia (285.9)
___ ___ Arthritis (716.9)
___ ___ Convulsions (780.3)
___ ___ Epilepsy (345.9)
___ ___ Cancer (199.1)
___ ___ Cold Sores (054.9)
___ ___ Depression (311)
___ ___ Headache (784.0)
___ ___ Fainting (780.2)
___ ___ Diabetes (250.0)
___ ___ Fatigue (chronic) (780.7)
___ ___ Gout (274.9)
___ ___ Sleep Problems (780.52)
___ ___ Loss of Weight (783.2)
___ ___ Nervousness (799.2)
___ ___ Tremors (781.0)
___ ___ Cerebral Palsy (343.9)
___ ___ Multiple Sclerosis (340)
___ ___ Obesity (278.0)
___ ___ Hernia (550.9)

DISEASES

___ ___ Rheumatic Fever (390)
___ ___ Tuberculosis (010.9)
___ ___ Malaria (084.6)
___ ___ Measles (055.9)
___ ___ Mumps (072.9)
___ ___ Small Pox (050.9)
___ ___ Scarlet Fever (034.1)
___ ___ Diphtheria (032)
___ ___ Typhoid Fever (002.0)
___ ___ Whooping Cough (033)
___ ___ Goiter (240.9)
___ ___ Influenza (487.1)
___ ___ Gonorrhea (098.0)
___ ___ Syphilis (097.9)
___ ___ Venereal Disease (099.9)
___ ___ Polio (045.9)

RESPIRATORY PROBLEMS

___ ___ Chest Pain (786.50)
___ ___ Chronic Cough (786.2)
___ ___ Asthma (493.9)
___ ___ Emphysema (492.8)
___ ___ Allergy (995.3)
___ ___ Difficult Breathing (786.09)
___ ___ Spitting Up Blood (786.3)
___ ___ Pleurisy (511.9)
___ ___ Spitting Up Phlegm (786.4)
___ ___ Pneumonia (486.0)
___ ___ Wheezing (786.09)

MUSCLE, JOINT & BONE

Now Have / Have Had

___ ___ Altered Gait (781.2)
___ ___ Painful/Stiff Neck (719.5)
___ ___ Backache (724.5)
___ ___ Muscle Spasms (728.85)
___ ___ Muscle Cramps (728.85)
___ ___ Bursitis (727.3)
___ ___ Tendonitis (727.9)
___ ___ Joint Paints (719.4)
___ ___ Swollen Joints (719.0)
___ ___ Arthritis (716.9)
___ ___ Shoulder Pain (719.4)
___ ___ Pain Between Shoulder (719.4)
___ ___ Hand/Wrist Pain (719.4)
___ ___ Hip Pain (719.4)
___ ___ Leg Pain (719.4)
___ ___ Knee Pain (719.4)
___ ___ Ankle/Foot Pain (719.4)
___ ___ Painful Tailbone (719.4)
___ ___ Poor Posture (781.9)
___ ___ Abnormal Spine (756.10)
___ ___ Spinal Curvature (737.9)
___ ___ Spinal Fracture (805.8)
___ ___ Scoliosis (737.30)
___ ___ Osteoporosis (733.0)

CARDIO-VASCULAR SIGNS

___ ___ Angina (413.9)
___ ___ Pacemaker (V45.0)
___ ___ Heart Attack (410.9)
___ ___ Heart Disease (414.9)
___ ___ Stroke (463)
___ ___ Hardening of Arteries (440.9)
___ ___ High Blood Pressure (401.9)
___ ___ Low Blood Pressure (458.9)
___ ___ Chest Pain (786.50)
___ ___ Poor Circulation (459.9)
___ ___ Rapid Heart Beat (785.0)
___ ___ Slow Heart Beat (427.89)
___ ___ Swelling of Ankles (459.9)

FOR WOMEN ONLY

___ ___ Lumps in Breast (611.72)
___ ___ Congested Breasts (611.79)
___ ___ Cramps or Backache (625.3)
___ ___ Excessive Menstrual Flow (626.2)
___ ___ Hot Flashes (627.2)
___ ___ Miscarriage (634.9)
___ ___ Irregular Cycle (626.4)
___ ___ Menopausal Symptoms (627.2)
___ ___ Painful Menstruation (625.3)
___ ___ Vaginal Discharge (623.5)

GASTRO-INTESTINAL PROBLEMS

Now Have / Have Had

___ ___ Blood in Stool (578.1)
___ ___ Belching or Gas (787.3)
___ ___ Colitis (558.9)
___ ___ Colon Trouble (564.9)
___ ___ Constipation (564.0)
___ ___ Diarrhea (558.9)
___ ___ Difficult Digestion (537.9)
___ ___ Distension of Abdomen (787.3)
___ ___ Gall Bladder Trouble (575.9)
___ ___ Heartburn (787.1)
___ ___ Hemorrhoids (455.6)
___ ___ Intestinal Worms (127.9)
___ ___ Jaundice (782.4)
___ ___ Liver Trouble (573.9)
___ ___ Nausea (787.0)
___ ___ Pain Over Stomach (536.8)
___ ___ Poor Appetite (783.0)
___ ___ Ulcers (533.9)
___ ___ Vomiting (787.0)
___ ___ Vomiting of Blood (578.0)

EYES, EARS, NOSE & THROAT

___ ___ Frequent Colds/Flu (460)
___ ___ Deafness (389.9)
___ ___ Enlarged Glands (785.6)
___ ___ Enlarged Thyroid (240.9)
___ ___ Eye Pain (379.91)
___ ___ Hoarseness (784.49)
___ ___ Nosebleeds (784.7)
___ ___ Sinus Infections (473.9)
___ ___ Sore Throat (462)
___ ___ Tonsilitis (474.9)
___ ___ Earache (388.70)
___ ___ Ear Noises (388.31)

SKIN PROBLEMS

___ ___ Eczema (692.9)
___ ___ Boils (580.9)
___ ___ Bruise Easily (782.7)
___ ___ Dryness (782.9)
___ ___ Hives or Allergy (708.9)
___ ___ Itching (698.9)
___ ___ Skin Eruptions (rash) (782.1)
___ ___ Varicose Veins (454.9)

GENITO-URINARY SYMPTOMS

Now Have / Have Had

___ ___ Bed-Wetting (788.3)
___ ___ Blood in Urine (599.7)
___ ___ Frequent Urination (788.4)
___ ___ Inability to Control Kidneys (788.3)
___ ___ Kidney Infections or Stones (590.9)
___ ___ Painful Urination (788.1)
___ ___ Prostate Trouble (601.9)
___ ___ Pus in Urine (599.0)

OPERATIONS

Please give dates of operations you have had

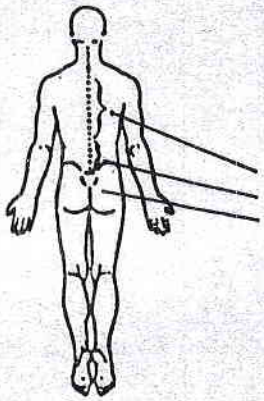
	Date
Appendectomy	
Gall Bladder	
Female Organs	
Heart	
Intestines	
Rectum	
Lungs	
Spine or Bones	
Back	
Stomach	
Kidneys	
Prostate	
Hernia	
Spinal Tap	
Spinal Injection	
Other	
Other	
Joint Replacement	
Pacemaker	
Metal Implant	

HABITS

Please give amounts used daily of the following:

Sleep (hours)	
Coffee	
Tea	
Alcohol	
Diet Drinks	
Soft Drinks	
Sugar	
Salt	
Diet	
Tobacco	
Exercise	
Hobbies	

PLEASE CHECK CONDITION YOU NOW SUFFER FROM:



Pain or Numbness				
Head	☐ Pain	☐ Numbness	☐ Right Side	☐ Left Side
Neck	☐ Pain	☐ Numbness	☐ Right	☐ Left
Shoulder	☐ Pain	☐ Numbness	☐ Right	☐ Left
Elbow	☐ Pain	☐ Numbness	☐ Right	☐ Left
Wrist	☐ Pain	☐ Numbness	☐ Right	☐ Left
Hand	☐ Pain	☐ Numbness	☐ Right	☐ Left
Fingers	☐ Pain	☐ Numbness	☐ Right	☐ Left
Mid Back	☐ Pain	☐ Numbness	☐ Right	☐ Left
Low Back	☐ Pain	☐ Numbness	☐ Right	☐ Left
Hip	☐ Pain	☐ Numbness	☐ Right	☐ Left
Thigh	☐ Pain	☐ Numbness	☐ Right	☐ Left
Knee	☐ Pain	☐ Numbness	☐ Right	☐ Left
Calf	☐ Pain	☐ Numbness	☐ Right	☐ Left
Ankle	☐ Pain	☐ Numbness	☐ Right	☐ Left
Foot	☐ Pain	☐ Numbness	☐ Right	☐ Left
Toes	☐ Pain	☐ Numbness	☐ Right	☐ Left

CURRENT PROBLEM

What is the main health problem you want to talk to the doctor about? _____

_____

How long have you had this condition? _____ When was the last time? _____

What activities aggravate your condition? _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Comes and goes ☐ Constant Number of episodes per day _____ per week _____ per mo. _____

Condition interfering with your ☐ work ☐ sleep ☐ daily routine ☐ other _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills ☐ None ☐ Other

MEDICATION	DOSAGE	REASON	DOCTOR

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY:
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had any fractures or dislocations?	☐	☐	
Had any accidents or falls?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	
Have you ever been in an auto accident?	☐	☐	

Does any member of your family have: (please circle)

arthritis heart disease cancer diabetes epilepsy lung disease emotional problems intestinal disorders scoliosis spinal arthritis neck or back pains abnormal spinal development other health problems? Yes / No Whom? Father Mother Sister Brother Aunt Uncle

PREVIOUS MEDICAL CARE FOR PRIMARY COMPLAINT

Name and Location of Doctor _____ Date attended _____

Hospital _____ Examinations and X-rays made _____

Condition or Diagnosis _____ Type of Treatment _____

Duration of Treatment _____ Results of Treatment Good, Fair, Poor _____

PREVIOUS CHIROPRACTIC CARE

Name and Location of Doctor _____ Date of last Spine & N.S. exam _____

What was problem _____ What did X-ray show _____

Cause of trouble explained by Dr. _____

Type of treatment _____ How often treated _____

How much time spent on each visit? _____ What was the total time patient was under care? _____

Results of Treatment Good, Fair, Poor _____ What other chiropractic care has patient had? _____

PLEASE SELECT THE TYPE OF CARE DESIRED so we can provide you with the best treatment and management of your condition.

☐ RELIEF CARE ☐ CORRECTIVE CARE ☐ COMPREHENSIVE CARE

☐ I WOULD LIKE TO KNOW WHAT THE DOCTOR THINKS IS BEST FOR ME.

I CERTIFY THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all services rendered. I agree that if my treatment here is suspended or terminated, fees become immediately due and payable. All X-rays are the property of this Chiropractic Center.

_____

SIGNATURE OF PATIENT OR GUARDIAN

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS SPACE

PRIMARY COMPLAINT

Exact description of problem _____

Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness
Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to ____ Severity 1 2 3 4 5 6 7 8 9 10
Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other
Better with: Exercise Rest Cold Heat Pain Pills Other _____

Related area of pain _____
Onset (how & when) _____ Date _____
Reoccurrence _____ Date _____ Same Better Worse than before
Related to fall or accident (describe) _____ Date _____
Did fall or accident occur at Home Work Other _____
Was Pt in Auto Accident _____ Date _____
Other circumstances assoc. with problem (complications) _____

SECONDARY COMPLAINT

Exact description of problem _____

Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness
Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to ____ Severity 1 2 3 4 5 6 7 8 9 10
Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other
Better with: Exercise Rest Cold Heat Pain Pills Other _____

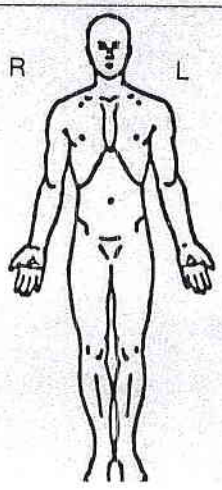
Related area of pain _____
Onset (how & when) _____ Date _____
Reoccurrence _____ Date _____ Same Better Worse than before
Related to fall or accident (describe) _____ Date _____
Did fall or accident occur at Home Work Other _____
Was Pt in Auto Accident _____ Date _____
Other circumstances assoc. with problem (complications) _____

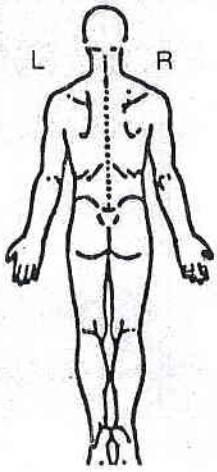
THIRD COMPLAINT

Exact description of problem _____

Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness
Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to ____ Severity 1 2 3 4 5 6 7 8 9 10
Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other
Better with: Exercise Rest Cold Heat Pain Pills Other _____

Related area of pain _____
Onset (how & when) _____ Date _____
Reoccurrence _____ Date _____ Same Better Worse than before
Related to fall or accident (describe) _____ Date _____
Did fall or accident occur at Home Work Other _____
Was Pt in Auto Accident _____ Date _____
Other circumstances assoc. with problem (complications) _____





Patient Denies Pregnancy
Signature _____
Date: _____