

DATE \_\_\_\_\_

ID # \_\_\_\_\_

### PERSONAL HISTORY

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Best # to reach you: \_\_\_\_\_ Email: \_\_\_\_\_

Appointment Reminder Preference:  No Reminders  Email  Text  Both Email & Text

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex  M  F Single Married Widowed Divorced Separated

Business Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Name/Ages of Children: \_\_\_\_\_

Name of Spouse/Parent: \_\_\_\_\_

Spouse/Parent Employer: \_\_\_\_\_ Spouse/Parent Occupation: \_\_\_\_\_

Referred to This Office By: Person \_\_\_\_\_ Website/Internet Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### CURRENT HEALTH CONDITION

Reason for your visit: \_\_\_\_\_

Other Doctors Seen For This Condition:  Yes  No Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before?  Yes  No

Is Condition:  Job Related  Auto Accident  Home Injury  Fall  Other: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Have You Made a Report of Your Accident to Your Employer/Auto Insurance carrier?  Yes  No

Who is Your Current Primary Care Physician? \_\_\_\_\_

When Was the Last Time You Saw Him/Her? \_\_\_\_\_ Reason: \_\_\_\_\_

Drugs You Now Take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine  Insulin

Other: \_\_\_\_\_

### PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery

Broken Bones  Other \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_

Hospitalizations (Other Than Above): \_\_\_\_\_

Previous Chiropractic Care:  None  Doctor's Name & Approximate date of Last Visit \_\_\_\_\_

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |                                  |               |                                      |
|--|--|---|----------------------------------|---------------|--------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        | <input type="checkbox"/> Measles | <b>INTAKE</b> |                                      |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Thyroid |               | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Eczema  |               | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> None    |               | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders |                                  |               | <input type="checkbox"/> Cigarettes  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          |                                  |               | <input type="checkbox"/> White Sugar |

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL CODE**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness
- None

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- None

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches
- None

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder problems
- Weight Problems
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stools
- Colitis
- None

**GENITO-URINARY CODE**

- Bladder Troubles
- Painful/Excessive Urination
- Discolored Urine
- None

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- None

**EENT CODE**

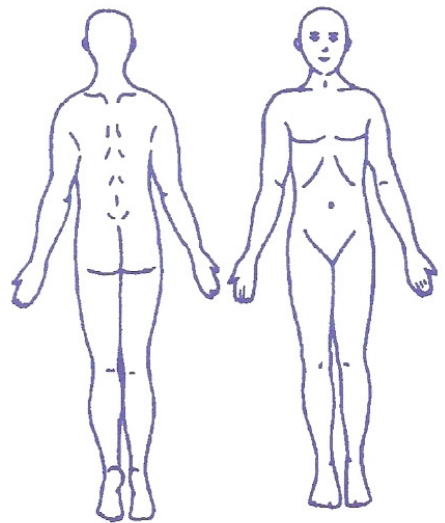
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulties
- Stuffed Nose
- None

**MALE/FEMALE CODE**

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/sexual Dysfunction
- Other Problems
- None
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_  
 First day of last period? \_\_\_\_\_  
 Are you pregnant?  
 Yes  No  Unsure



Please outline on the diagram the area of your discomfort

**FAMILY HISTORY**

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child
- None

Doctor Name: Scott D. Casses, D.C./ Rochelle L. Casses, D.C. / Chastity A. Keller, D.C.  
 Doctor Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Employment, ADL, and Recreation Information

Please fill in your name and then answer the questions below indicating how your current condition affects your ability to perform the activities listed.

Patient name \_\_\_\_\_ File # \_\_\_\_\_ Date \_\_\_\_\_

Initial Exam \_\_\_\_\_ Re-activation \_\_\_\_\_ Re-evaluation Exam \_\_\_\_\_

Description of Work: \_\_\_\_\_

Condition's Effect On Job Performance:  No Effect  Mild (painful can do)  Mod (painful limited ability)  
 Mod/Sev (limited duty)  Sev (no limited duty)  Sev (can't do limited duty)

## Daily Activities: Effects of Current Condition on Performance

- Bending:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Care –Infirm Family:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Carrying Groceries:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Change Posn–Sit–Stand:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Climb Stairs:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Driving:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Extended Computer Use:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Feeding:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Household Chores:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Kneeling:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Lift Children:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Lifting:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Pet Care:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Reading (Concentration):  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Self Care–Bathing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Self Care–Dressing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Self Care–Shaving:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Sleep:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Static Sitting:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Static Standing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Walking:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform
- Yard Work:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform

## Recreational Activity: Effects of Current Condition on Performance

- \_\_\_\_\_  No Effect  Mild Painful (Can do)  Mod Painful (limited)  Sev Unable to Perform
- \_\_\_\_\_  No Effect  Mild Painful (Can do)  Mod Painful (limited)  Sev Unable to Perform
- \_\_\_\_\_  No Effect  Mild Painful (Can do)  Mod Painful (limited)  Sev Unable to Perform

SCOTT D. CASSES, D.C. \_\_\_\_\_ Date \_\_\_\_\_

ROCHELLE L. CASSES, D.C. \_\_\_\_\_ Date \_\_\_\_\_

CHASTITY A. KELLER, D.C. \_\_\_\_\_ Date \_\_\_\_\_