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

For Text Reminders: Cell Phone Carrier: AT& T Sprint Verizon T-Mobile Other: ___________

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:

☐Pneumonia
☐ Rheumatic Fever
☐Polio
☐Tuberculosis
☐Whooping Cough
☐Anemia
☐Mumps
☐Small Pox
☐Chicken Pox
☐Diabetes
☐Cancer
☐Heart Disease
☐Influenza
☐Pleurisy
☐Arthritis
☐Epilepsy
☐Mental Disorders
☐Lumbago
☐Measles
☐Thyroid
☐Eczema
☐None

INTAKE

☐Coffee
☐Tea
☐Alcohol
☐Cigarettes
☐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-INTESTIONAL 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

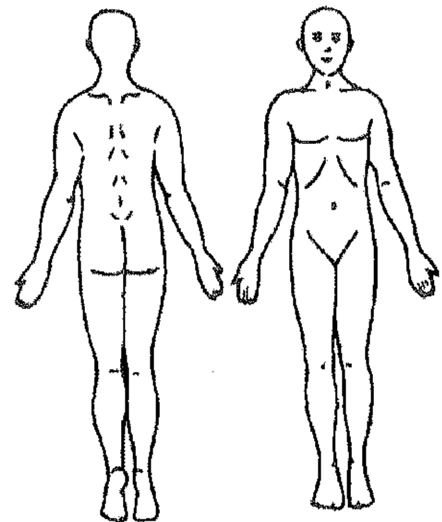
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Ear Aches
☐Hearing Difficulties
☐Stuffed Nose
☐None

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

Activity				
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

Activity				
__________________	☐ **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 _____________