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, List Cell Phone Carrier:_____

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	☐Mumps	☐Influenza	☐Measles	**INTAKE**
☐ Rheumatic Fever	☐Small Pox	☐Pleurisy	☐Thyroid	☐Coffee
☐Polio	☐Chicken Pox	☐Arthritis	☐Eczema	☐Tea
☐Tuberculosis	☐Diabetes	☐Epilepsy	☐None	☐Alcohol
☐Whooping Cough	☐Cancer	☐Mental Disorders		☐Cigarettes
☐Anemia	☐Heart Disease	☐Lumbago		☐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

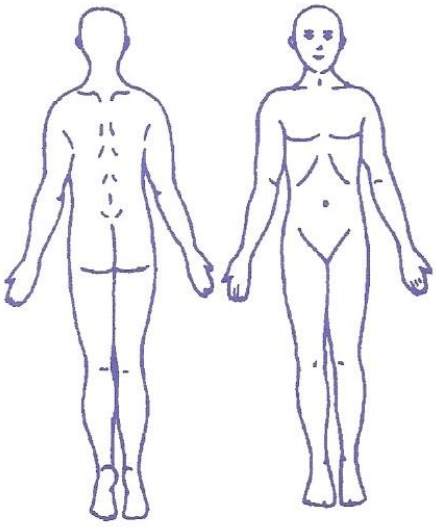
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Ear Aches
☐Hearing Difficulties
☐Stuffed Nose
☐None

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

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 _____