TODAY'S DATE: _____

PATIENT INFORMATION

Name: (Last)_____ (First)_____ (Middle Initial)_____

Address:_____

City:_____ State:_____ Zip:_____

Home Number:_____ Work Number:_____ Cell number:_____

E-mail Address: _____ May we leave messages at the above numbers ☐ Yes ☐ No

Birth Date:_____ Sex: ☐ Male ☐ Female Social Security number:_____

Relationship to Policyholder: ☐ Same ☐ Spouse ☐ Child ☐ Other _____

Patient Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Student

Occupation:_____ Employer's Name:_____ Phone Number:_____

Referred to Office by: ☐ Doctor ☐ Friend ☐ Walk/Drive-by ☐ Yellow Pages ☐ Newspaper ☐ Insurance List ☐ Internet ☐ Other _____

INSURANCE INFORMATION

Primary Insurance:_____ Phone:_____

Address:_____

Policy Claim Number:_____ Group #:_____

Check box if the following information has been completed above: ☐ Information Completed

Policyholder's Name: (Last)_____ (First)_____ (Initial)_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Birth Date:_____ Sex: ☐ Male ☐ Female Social Security number:_____

Secondary Insurance:_____ Phone:_____

Address:_____

Policy Claim Number:_____ Group #:_____

Check box if the following information has been completed above: ☐ Information Completed

Policyholder's Name: (Last)_____ (First)_____ (Initial)_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Birth Date:_____ Sex: ☐ Male ☐ Female Social Security number:_____

Name:_____

Date:_____

CURRENT SYMPTOMS/COMPLAINTS

Have you ever seen a chiropractor before? ☐ yes ☐ no If yes, when and why? _____

_____

Reason for today's visit? _____

Have you had a similar condition in the past? ☐ yes ☐ no

If you have been injured, are your complaints related to a(n):

☐ Auto Accident
☐ Work Injury
☐ Sports Injury

} Please provide date of injury:_____

☐ Other (please describe): _____

_____

When did the current symptom(s)/pain begin? _____

If you are in pain, is it: ☐ improving ☐ remaining the same ☐ worsening

How often is there pain: ☐ constant (76-100%) ☐ frequent (51-75%) ☐ occasional (26-50%) ☐ intermittent (0-25%)

Does the pain interfere with: ☐ work ☐ sleep ☐ recreation ☐ daily routine ☐ mood and irritability

Have you been treated by anyone else for this condition? ☐ yes ☐ no If yes, what treatment have you received and who administered this treatment? Type of care received_____

Name of facility/doctor:_____

Results of care: ☐ positive ☐ no change ☐ other If other, please explain: _____

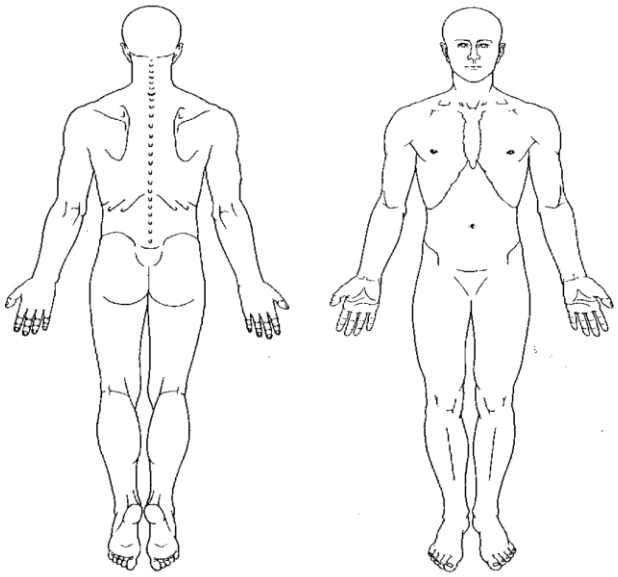
Which of the following activities are difficult to perform due to the pain? (mark all that apply)

☐ Laying on back	☐ Bending forward	☐ Pushing/pulling	☐ Walking
☐ Laying on stomach	☐ Bending backward	☐ Twisting	☐ Sitting
☐ Laying on side	☐ Standing for long periods of time	☐ Reaching	☐ Getting in/out of car
☐ Turning over in bed	☐ Getting in/out of seated position	☐ Kneeling	☐ Sneezing/Coughing
☐ Getting Dressed	☐ Working at a computer/desk	☐ Gripping	☐ Other:_____

PAIN RATING

Please indicate on the drawing the location of your pain or discomfort. Use the symbols shown below to represent the type(s) of pain:

D=Dull Ache
B=Burning
N=Numbness
S=Stabbing/Sharp
T=Tingling
X=Stiffness/Tightness
O=Spasm



Please rate the severity of your chief complaint pain (10 = worst pain):

At its **worst**:

0 1 2 3 4 5 6 7 8 9 10

At its **best**:

0 1 2 3 4 5 6 7 8 9 10

Currently:

0 1 2 3 4 5 6 7 8 9 10

Name:_____

Date:_____

PAST HEALTH HISTORY

Please check the box located next to the condition or symptom listed below in which you now have or have had previously. It is important to know your health history so that we can provide the highest quality of care for you. This report is confidential.

GENERAL HEALTH
- ☐ Allergies
- ☐ Seizure
- ☐ Dizziness or fainting
- ☐ Headache
- ☐ Numbness

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Sciatica
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Middle back pain
- ☐ Swollen joints
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Leg pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot pain

GASTRO-INTESTINAL
- ☐ Acid-reflux
- ☐ Colon trouble
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Difficult digestion
- ☐ Gall bladder trouble
- ☐ Liver trouble
- ☐ Stomach pain

EYES, EARS, NOSE, & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noise
- ☐ Ear pain
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Sinus infection or trouble

CARDIO-VASCULAR
- ☐ Heart attacks
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of Ankles

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Spitting up mucous
- ☐ Wheezing

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Blood urine
- ☐ Frequent urination
- ☐ Bladder control
- ☐ Bladder infections
- ☐ Prostate trouble
- ☐ Painful urination

SKIN
- ☐ Bruise easily
- ☐ Dryness
- ☐ Rashes
- ☐ Varicose veins

If you feel an explanation is needed, you may use this space. _____

_____

_____

FAMILY HEALTH HISTORY

CHECK THE BOXES OF THE FOLLOWING CONDITIONS YOU HAVE OR HAD AND **CIRCLE** THE CONDITIONS THAT MAY RUN IN YOUR FAMILY.

☐ AIDS	☐ ALCOHOLISM	☐ ANEMIA	☐ APPENDICITIS	☐ ARTERIOSCLEROSIS
☐ CANCER	☐ DIABETES	☐ ECZEMA	☐ EMPHYSEMA	☐ EPILEPSY
☐ GOITER	☐ GOUT	☐ HEART DISEASE	☐ MALARIA	☐ MEASLES
☐ MULTIPLE SCLEROSIS		☐ MUMPS	☐ PACEMAKER	☐ PNEUMONIA
☐ POLIO	☐ STROKE	☐ TUBERCULOSIS	☐ ULCERS	☐ VENEREAL DISEASE

MEDICATIONS / SUPPLEMENTS

Please list any current dietary supplements, prescription and/or over-the-counter medications and reason for use:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name:_____

Date:_____

PERSONAL HEALTH

Have you in the past had any surgeries of any kind? ☐ yes ☐ no If yes, please explain _____

_____

Is there any chance that you may be pregnant? ☐ yes ☐ no If yes, when are you due?_____

How often do you exercise? ☐ daily ☐ 3-5 days per week ☐ 1-2 days per week ☐ 0 days per week

Type of exercise: ☐ cardio-vascular ☐ weight or resistance training ☐ Core stabilization ☐ other

If other, please explain _____

	None	Light	Moderate	Heavy
ALCOHOL USE				
COFFEE USE				
TOBACCO USE				
DRUG USE (non Rx)				
SOFT DRINK USE				

	Date of most recent:
Physical Exam	
Blood Test	
Urinalysis	
Chest X-ray	
Spinal X-ray	

Name and location of Primary Care Physician: _____

Do you authorize Cascades Chiropractic to correspond with your Primary Care Physician or other involved health care providers about your care? ☐ yes ☐ no

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions and filled out this form completely.

Sign your name _____ Date _____

DOCTOR'S NOTES