

DATE _____

ID # _____

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Best # to reach you: _____ Email: _____

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 _____ Mailer _____ Newspaper _____

Event: _____ 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: _____

Do You Wear a Shoe Lift? Yes No

Do You Suffer From Any Other Condition Other Than Which You Are Now Consulting Us? _____

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 | INTAKE | |
| <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
- None

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

GENTO-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

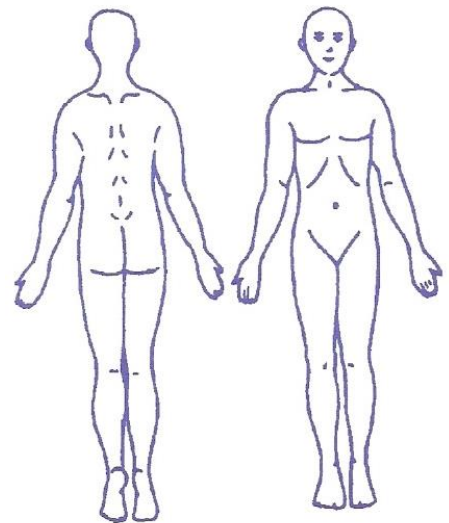
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulties
- Stuffed Nose
- None

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

Recreational Activity: Effects of Current Condition on Performance

- | | | | | |
|-------|---|---|---|---|
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |

SCOTT D. CASSES, D.C. _____ Date _____

ROCHELLE L. CASSES, D.C. _____ Date _____

CHASTITY A. KELLER, D.C. _____ Date _____