Dobias Chiropractic Office
175 Delaware Avenue
Palmerton, PA 18071

CASE NO. _____

Please fill out the following form in as much detail as possible.

Please Print Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

E-mail Address _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) _____ (F) _____

Weight _____ Referred By _____

Employer _____ Address _____

Married __ S __ W __ D __ Children_____ Name of Spouse _____

Is any other member of your family being treated at this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes _____ No _____ N/A _____

Major complaints and symptoms -- please be as specific as you can be. Ask the doctor or nurse for help if you need assistance in filling out this section.

_____

_____

_____

_____

How do you believe your problem (pain) began? _____

_____

CONFIDENTIAL CASE HISTORY RECORD

When did you first notice this problem/pain? _____

Have you lost any work? _____ Day and date you last worked _____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

Have you been treated by a Medical Physician for this ailment? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes____ No ___

Will this case be covered by any insurance company? Major Medical ___ Auto ___

Blue Cross/Blue Shield ___ Workers' Compensation ___ Medicare ___ Other ___

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc.

(even as a child)?_____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication (aspirin included)? Yes ____ No ____

If Yes, name them _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Have you had any cosmetic surgery, breast implants, etc? _____ Year _____

Have you had any surgery to replace hip, knee, etc? _____ Year _____

Give dates you have had any of the following? (If exact date is unknown, give approximate date)

Blood Tests _____ Urinalysis _____

MRI _____ CT Scan _____ Ultrasound _____

Radiation Treatment _____ X-ray examination _____

At what hospital or office were these test taken? _____

Name of doctor who ordered tests _____

Date of last menstrual period _____

Do you have any reason to believe you may be pregnant? Yes ___ No___

Do you have any health problems not listed above? _____

Do you faint easily? _____

Do you take vitamins? Yes ___ No ___ If yes, please list them _____

Do you exercise regularly? Yes ___ No ___ What kind of exercise? _____

Habits: (please check)

Cigarettes? _____ Quantity _____ Coffee? _____ Quantity _____

Alcohol? _____ Quantity _____ Tea? _____ Quantity _____

Hobbies _____

Have you been treated for any health condition by a physician in the past year? _____

If Yes, what condition? _____

Have you lost or gained weight in the past year? _____

Use this space for any additional information you may wish to discuss _____

_____

_____

_____

_____

_____

_____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now N	Past P		Now N	Past P
Headaches_____ Frequency	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in Arms	_____	_____	Colitis	_____	_____
Weakness in Legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Lights Bother Eyes	_____	_____	Shoulder Pain	_____	_____
Loss of Memory	_____	_____	Swelling Joints	_____	_____
Ears Ring	_____	_____	Knee Pain	_____	_____
Face Flushed	_____	_____	Hayfever	_____	_____
Buzzing in Ears	_____	_____	Menstrual Difficulties	_____	_____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE _____

Dobias Chiropractic Office 175 Delaware Ave. Palmerton, PA 18071

PATIENT NAME: _____ Case No. _____

DATE OF BIRTH: _____

DATE _____

Do you have chest pain?	Yes ____	No____
Do you have any change in bowel or bladder habbits?	Yes ____	No____
Do you have a sore that does not heal?	Yes ____	No____
Do you have any unusual bleeding or discharge?	Yes ____	No____
Do you have any thickening in your breasts or elsewhere?	Yes ____	No____
Do you have indigestion or difficulty in swallowing?	Yes ____	No____
Do you have a change in any wart or mole?	Yes ____	No____
Do you have a nagging cough or hoarseness?	Yes ____	No____
Do you have headaches for hours or days?	Yes ____	No____
Do you have blurred vision?	Yes ____	No____
Do you have night sweats?	Yes ____	No____
Do you have pain in neck, jaw or face?	Yes ____	No____
Do you have a drooping eyelid or any change in your pupils?	Yes ____	No____
Do you have vertigo (dizziness)?	Yes ____	No____
Do you have double vision?	Yes ____	No____
Do you have any visual disturbances?	Yes ____	No____
Do you have any nausea or vomiting?	Yes ____	No____
Do you have any slurred speech?	Yes ____	No____
Do you have any ringing in your ears?	Yes ____	No____
Do you pass out easily (faint) ?	Yes ____	No____
Do you take birth control pills?	Yes ____	No____
Do you have a history of stroke in your family?	Yes ____	No____

What prescription medication are you taking if any?

[ ] High blood pressure medication

[ ] Blood thinners

[ ] Other _____

_____

_____

HISTORY CHECKLIST

Have you ever had cancer? Yes ____ No____
Does your pain ever wake you from a sound sleep? Yes ____ No____
Are you losing weight now without trying? Yes ____ No____
Are you coughing up blood or noticing it in your stools or urine? Yes ____ No____
Have you had any loss of bladder or bowel control? Yes ____ No____
Have you lost consciousness or had double vision recently? Yes ____ No____
Are you seeing any other doctor now for any reason? Yes ____ No____
Note: _____
Are you taking any medications or over-the-counter drugs? Yes ____ No____
Please indicate type (aspirin, etc) _____
What was the date of your last menses? _____

SOCIAL HISTORY

SMOKER ____ YES or ____ NO, If Yes, How many packs? _____
ALCOHOL ____ YES or ____ NO, If Yes, How much? _____

FAMILY HISTORY

Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizures-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Ulcer or Stomach Problems
( ) Stroke
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer

Comments: _____

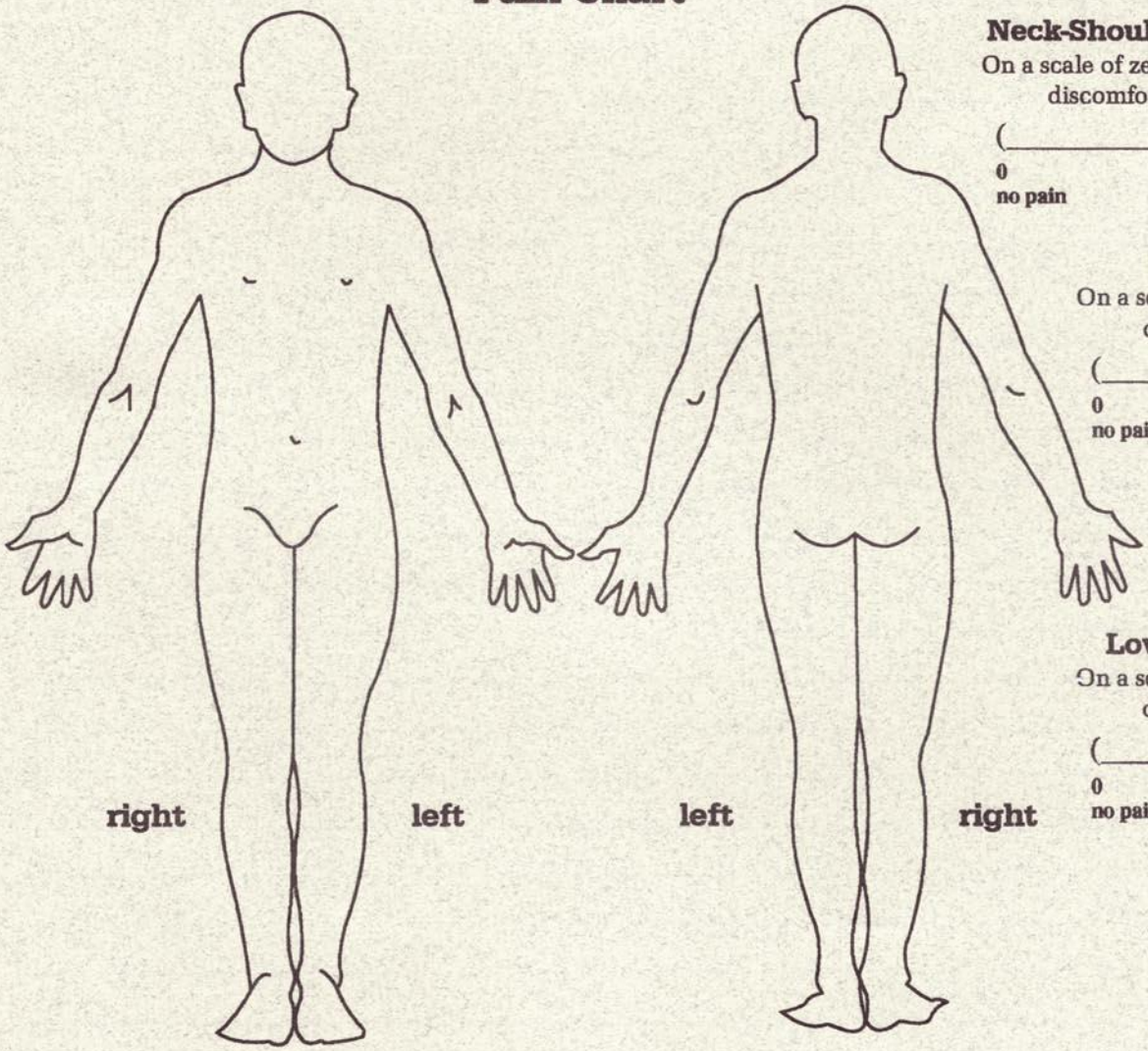
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
--------	00000000	xxxxxxx	*******	///////
--------	00000000	xxxxxxx	*******	///////
--------	00000000	xxxxxxx	*******	///////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 **no pain** — **10** **severe pain**

Mid-Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 **no pain** — **10** **severe pain**

Low Back & Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 **no pain** — **10** **severe pain**

Date: _____

_____

Signature: