CARAOTTA CHIROPRACTIC ORTHOPEDICS

DR. LANCE MYERS DR. NICHOLAS MICKA DR. JASON McAFEE

Chiropractic Case History/Patient Information

Date_____ Patient #_____ Doctor _____

Name_____Social Security # _ _ _-_ _-_ _ _ _ Home Phone_____

Address _____ City_____ State_____ Zip_____

E-mail address _____ Fax#_____Cell Phone_____

Age_____Birth Date_____Race _____**MARITAL: M S W D How many children?____

Occupation_____ Employer_____

Employer's Address _____Office Phone_____

Spouse _____ Occupation_____Employer_____

Name of Nearest Relative_____Address_____Phone_____

How were you referred to our office?_____

Family Medical Doctor_____

Purpose of this appointment_____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe:_____

_____

Days lost from work_____

Date of last physical examination _____**WHAT SURGERIES HAVE YOU HAD (include dates)__

_____

Serious illness (include dates)_____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe:_____

_____

**WHAT MEDICATIONS ARE YOU TAKING?_____

_____

**DO YOU HAVE ANY ALLERGIES? □ Yes □ No If yes, describe_____

Please check any and all insurance coverage that may be applicable in this case.

□ Major Medical □ Worker's Compensation □ Medicaid

□ Medicare □ Auto Accident □ Other

Name of Primary Insurance Company_____

Name of Secondary Insurance Company (if any)_____

Turn page to continue

CHECK THE FOLLOWING SYMPTOMS YOU HAVE HAD:

GENERAL
- □ Allergy
- □ Chills
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Headache
- □ Loss of sleep
- □ Loss of weight
- □ Nervousness/depression
- □ Neuralgia
- □ Numbness
- □ Sweats
- □ Tremors

CARDIO-VASCULAR
- □ Hardening of arteries
- □ High blood pressure
- □ Low blood pressure
- □ Pain over heart
- □ Poor Circulation
- □ Rapid heart beat
- □ Slow heart beat
- □ Swelling of ankles

MUSCLE & JOIN
- □ Arthritis
- □ Bursitis
- □ Foot trouble
- □ Hernia
- □ Low back pain
- □ Lumbago
- □ Neck pain or stiffness
- □ Pain between shoulders

Pain or numbness in:
- □ Shoulders
- □ Arms
- □ Elbows
- □ Hands
- □ Hips
- □ Legs
- □ Knees
- □ Feet

- □ Painful tail bone
- □ Poor posture
- □ Sciatica
- □ Spinal curvature
- □ Swollen joints

EYES, EARS, NOSE & THROAT
- □ Asthma
- □ Colds
- □ Crossed Eyes
- □ Deafness
- □ Dental decay
- □ Earache
- □ Ear discharge
- □ Ear noises
- □ Enlarges glands
- □ Enlarged thyroid
- □ Eye Pain
- □ Failing vision
- □ Far sightedness
- □ Gum trouble
- □ Hay fever
- □ Hoarseness
- □ Nasal obstruction
- □ Near sightedness
- □ Nosebleeds
- □ Sinus Infection
- □ Sore throat
- □ Tonsilitis

RESPIRATORY
- □ Chest Pain
- □ Chronic Cough
- □ Difficult breathing
- □ Spitting up blood
- □ Spitting up phlegm
- □ Wheezing

GASTRO-INTESTINAL
- □ Belching or gas
- □ Colitis
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficult digestion
- □ Distension or abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids
- □ Intestinal worms
- □ Jaundice
- □ Liver trouble
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting
- □ Vomiting of blood

SKIN
- □ Boils
- □ Bruise Easily
- □ Dryness
- □ Hives or allergy
- □ Itching
- □ Skin eruptions (rash)
- □ Varicose veins

GENITO-URINARY
- □ Bed wetting
- □ Blood in urine
- □ Frequent urination
- □ Inability to control kidneys
- □ Kidney infection or stones
- □ Painful urination
- □ Prostate trouble
- □ Pus in urine

FOR WOMEN ONLY
- □ Congested breasts
- □ Cramps or backache
- □ Excessive menstrual flow
- □ Hot flashes
- □ Irregular cycle
- □ Menopausal symptoms
- □ Painful menstruation
- □ Vaginal discharge

HAVE YOU EVER:	YES	NO
Been knocked unconscious?	□	□
Used a cane, crutch, or other support?	□	□
Been treated for a spine or nerve disorder?	□	□
Had a fracture bone?	□	□
Been hospitalized for other than surgery?	□	□
DO YOU:		
Now take vitamins or minerals?	□	□
Think you may need vitamins or minerals?	□	□
Have an allergy to any drug?	□	□
***HAVE DIABETES?**	□	□

DATE OF LAST	Less than 6 months	Over 6-18months	18 months	Never
Spinal examination	□	□	□	□
Physical examination	□	□	□	□
Blood test	□	□	□	□
Chest X-ray	□	□	□	□
Spinal X-ray	□	□	□	□
Dental X-ray	□	□	□	□
Urine test	□	□	□	□

HABITS (CIRCLE ONE FOR EACH)

***ALCOHOL**	Heavy	Moderate	Casual	None
***COFFEE** (drinks per day)	6	3-6	0-3	None
***TOBACCO**	Former	Current	Never	
***NON PRESC. DRUGS**	YES	NO IF YES, EXPLAIN_____		
***EXERCISE**	Daily	Weekly	Walks	Runs	Swims	Never
Sleep	Heavy	Moderate	Light	None		
Appetite	Heavy	Moderate	Light	None		

DESCRIBE BRIEFLY

_____

_____

_____

*** FAMILY HISTORY: (PLEASE LIST FAMILY MEMBER [MOTHER, FATHER, ETC.] NEXT TO CONDITION)**

CANCER _____HIGH BLOOD PRESSURE_____

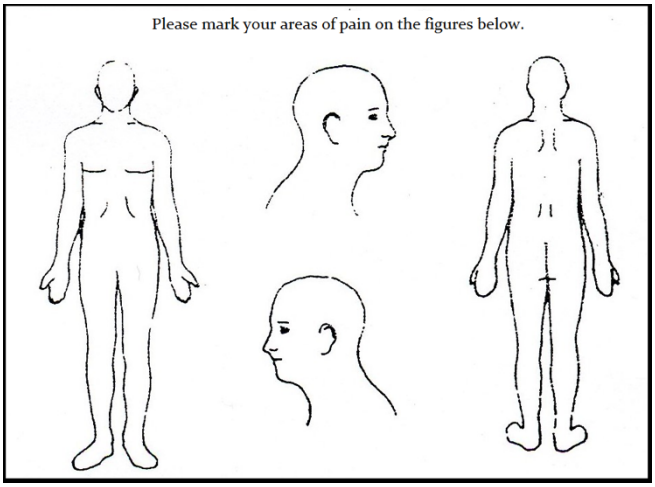
DIABETES_____STROKE_____

OSTEOPOROSIS_____OTHER_____

*** HEIGHT_____ WEIGHT_____**

***** (FOR DR'S USE ONLY) **BP** _____/_____ **PULSE**_____

Please mark your areas of pain on the figures below.



ARE YOU PREGNANT? □ YES □ NO

PLEASE CHECK THE TYPE OF CARE YOU DESIRE SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE

□ I PREFER THE DOCTOR TO SELECT THE TYPE OF CARE HE/SHE FEELS IS BEST FOR ME

□ MAXIMUM IMPROVEMENT

□ TEMPORARY RELIEF

ARE YOU INSURED? □ **YES** □ **NO** **COMPANY** _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHRMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO TE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE 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 SERVICE RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

Patients Signature _____ **Date**_____

Guardian or Spouse's Signature Authorizing Care _____ **Date**_____

Information taken by: