Appleton Spine Institute

Case History

Name ______________________________ Age ________ Date ______________ Email ________________

Address ______________________________ City ________________ State________ Zip ______________

Phone (H)______________ (Cell)______________ Date of Birth__________ Sex: M F Marital Status: S M D W #Children_______

Occupation ____________________ Employer ____________________ Phone (Work) ________________

Insured's Name ____ Insured's Date of Birth ________________

Referred by ______________________________ Past Chiropractic Care? ☐ Yes ☐ No When______________

Doctor's Name ______________________________ Results ______________________________

Insurance Company ______________________________ Phone______________________________

Social Security# ______________________________ Driver's License# ______________________________

Spouse's Name ______________________________ Spouse's Occupation______________________________

Spouse's Employer ______________________________ Spouse's Phone (work) ______________________________

Spouse's Insurance Company______________________________ Phone______________________________

Spouse's Social Security#______________________________ Spouse's Driver's License# ______________________________

Chief Complaint

List Current Problems

1. ______________________________ Duration-(How Long) __________ Previous Episodes__________
2. ______________________________ Duration-(How Long) __________ Previous Episodes __________
3. ______________________________ Duration-(How Long) __________ Previous Episodes __________

Are your present problems due to an injury? ☐ Yes ☐ No ☐ On the job ☐ Auto Accident ☐ Personal Injury ☐ Other ________________

Has the accident been reported? ☐ Yes ☐ No ☐ To Employer ☐ Auto Carrier ☐ Other ________________

Have you retained an attorney? ☐ Yes ☐ No Name & Address ______________________________

Please mark the intensity of your pain today

1 — NO PAIN
10— MOST INTENSE EVER FELT

Example ______ Neck ______

1 2 3 ④ 5 6 7 8 9 10

1. ______________________________
1 2 3 4 5 6 7 8 9 10

2. ______________________________
1 2 3 4 5 6 7 8 9 10

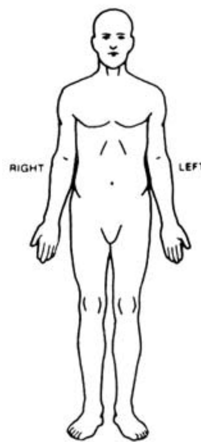
3. ______________________________
1 2 3 4 5 6 7 8 9 10

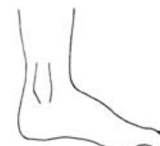
DOCTORS USE ONLY

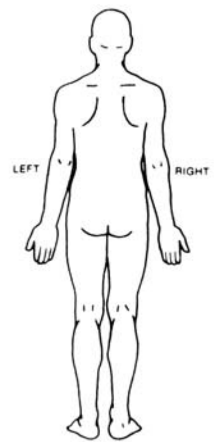
____
____
____
____
____

Please mark area and type of pain on the drawings using the code listed below.

N — Numbness
T — Tingling
S — Soreness
P — Pain
A — Ache
ST — Stiffness







HABITS

☐ Smoking Packs/Day __________
☐ Drinking Alcohol __________
☐ Coffee Cups/Day__________

EXERCISE

☐ None
☐ Moderate
☐ Daily
Type__________
____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No. of ______	☐	☐	☐	☐	☐
Sister, No. of ______	☐	☐	☐	☐	☐

Have You Had Any of the Following Diseases?

☐ 541 Appendicitis
☐ 480 Pneumonia
☐ 390 Rheumatic Fever
☐ 045 Polio
☐ 011 Tuberculosis
☐ 033 Whooping Cough
☐ 280 Anemia
☐ 055 Measles
☐ 072 Mumps
☐ 052 Chicken Pox
☐ 250 Diabetes
☐ 239 Cancer
☐ 429.9 Heart Disease
☐ 240 Goiter
☐ 487 Influenza
☐ 511 Pleurisy
☐ 305.0 Alcoholism
☐ 099 Venereal Infection
☐ 716 Arthritis
☐ 345 Epilepsy
☐ 319 Mental Disorder
☐ 724.2 Lumbago
☐ 690 Eczema
☐ 044 HIV Positive

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ☐ Never; ☐ Previously; ☐ Presently.

GENERAL SYMPTOMS

Never	Previously	Presently	Code	Symptom
☐	☐	☐	995.3	Allergy (What) _____ ______________________
☐	☐	☐	491	Bronchitis
☐	☐	☐	780.9	Chills
☐	☐	☐	780.3	Convulsions
☐	☐	☐	780.4	Dizziness
☐	☐	☐	780.2	Fainting
☐	☐	☐	780.7	Fatigue
☐	☐	☐	780.6	Fever
☐	☐	☐	784.0	Headache
☐	☐	☐	780.52	Loss of Sleep
☐	☐	☐	783	Loss of Weight
☐	☐	☐	799.2	Nervousness
☐	☐	☐	729.2	Neuralgia
☐	☐	☐	780.8	Night Sweats
☐	☐	☐	782	Numbness or pain in arms/legs/hands
☐	☐	☐	786.09	Wheezing

MUSCLES & JOINTS

Never	Previously	Presently	Code	Symptom
☐	☐	☐	724.5	Backache
☐	☐	☐	719.7	Foot Trouble
☐	☐	☐	550.0	Hernia
☐	☐	☐	719.1	Pain Between Shoulders
☐	☐	☐	724.6	Painful Tail Bone
☐	☐	☐	723.9	Stiff Neck
☐	☐	☐	781.9	Spinal Curvature
☐	☐	☐	719.0	Swollen Joints
☐	☐	☐	781.0	Tremors
☐	☐	☐	781.0	Twitching
☐	☐	☐	728.8	Weakness

GASTROINTESTINAL

Never	Previously	Presently	Code	Symptom
☐	☐	☐	787.3	Belching or Gas
☐	☐	☐	789.0	Colon Trouble
☐	☐	☐	564.0	Constipation
☐	☐	☐	558.9	Diarrhea
☐	☐	☐	783.6	Excessive Hunger
☐	☐	☐	575.9	Gall Bladder Trouble
☐	☐	☐	455.6	Hemorrhoids (Piles)
☐	☐	☐	782.4	Jaundice
☐	☐	☐	794.8	Liver Trouble
☐	☐	☐	787.0	Nausea
☐	☐	☐	536.8	Pain over Stomach
☐	☐	☐	783.0	Poor Appetite
☐	☐	☐	536.8	Poor Digestion
☐	☐	☐	787.0	Vomiting
☐	☐	☐	578.0	Vomiting Blood

CARDIOVASCULAR

Never	Previously	Presently	Code	Symptom
☐	☐	☐	401.9	High Blood Pressure
☐	☐	☐	458.9	Low Blood Pressure
☐	☐	☐	786.51	Pain over Heart
☐	☐	☐	785.9	Poor Circulation
☐	☐	☐	438	Previous Heart Trouble
☐	☐	☐	785.0	Rapid Heart
☐	☐	☐	427.89	Slow Heart
☐	☐	☐	436	Strokes
☐	☐	☐	782.3	Swelling Ankles
☐	☐	☐	454	Varicose Veins

EYE/EAR/NOSE/THROAT

Never	Previously	Presently	Code	Symptom
☐	☐	☐	493.9	Asthma
☐	☐	☐	378.9	Crossed Eyes
☐	☐	☐	389.9	Deafness
☐	☐	☐	388.70	Earache
☐	☐	☐	388.60	Ear Discharges
☐	☐	☐	388.30	Ear Noises
☐	☐	☐	240.9	Enlarged Thyroid
☐	☐	☐	460	Frequent Colds
☐	☐	☐	477.9	Hay Fever
☐	☐	☐	784.49	Hoarseness
☐	☐	☐	478.1	Nasal Obstruction
☐	☐	☐	784.7	Nose Bleeds
☐	☐	☐	379.91	Pain in Eyes
☐	☐	☐	368.9	Poor Vision
☐	☐	☐	473.9	Sinusitis
☐	☐	☐	462	Sore Throats
☐	☐	☐	463	Tonsillitis

SKIN OR ALLERGIES

Never	Previously	Presently	Code	Symptom
☐	☐	☐	690	Boils
☐	☐	☐	924.9	Bruising Easily
☐	☐	☐	701.1	Dryness
☐	☐	☐	691.8	Eczema
☐	☐	☐	708.9	Hives or Allergy
☐	☐	☐	698.9	Itching
☐	☐	☐	782.0	Sensitive Skin
☐	☐	☐	368.9	Skin Eruptions

RESPIRATORY

Never	Previously	Presently	Code	Symptom
☐	☐	☐	786.50	Chest Pain
☐	☐	☐	786.2	Chronic Cough
☐	☐	☐	786.09	Difficulty Breathing
☐	☐	☐	786.3	Spitting Blood
☐	☐	☐	786.4	Spitting Phlegm

GENITO-URINARY

Never	Previously	Presently	Code	Symptom
☐	☐	☐	788.3	Bed Wetting
☐	☐	☐	599.7	Blood in Urine
☐	☐	☐	788.4	Frequent Urination
☐	☐	☐	788.3	Inability to Control Urine
☐	☐	☐	590.9	Kidney Infection
☐	☐	☐	788.1	Painful Urination
☐	☐	☐	601.9	Prostate Trouble

FOR WOMEN ONLY

Never	Previously	Presently	Code	Symptom
☐	☐	☐	625.3	Cramps or Backaches
☐	☐	☐	626.2	Excessive Flow
☐	☐	☐	627.2	Hot Flashes
☐	☐	☐	626.4	Irregular Cycle
☐	☐	☐	634.9	Miscarriage
☐	☐	☐	625.3	Painful Periods
☐	☐	☐	623.5	Vaginal Discharge

☐ No ☐ Pregnant at this Time

______ Last Pap Date

By Whom ____________________

____

Doctor Notes:

____

____

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____

____

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____

____

List any broken bones (fractures), dislocations or surgeries: ________________________________

☐ I have never had any operations/surgeries.

Do you suffer from any condition other than that for which you are now consulting us? ____________________

Are you presently taking any medication or supplements—prescription or over-the-counter? ☐ No ☐ Yes—What? ____________

____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor’s Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor’s Office will be credited to my account on 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 services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. The patient understands and agrees to allow ASI to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. For more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE available at the front desk before signing this consent.

Patient’s/Guardian’s Signature X ______________________________ Date ____________________