BACK TO HEALTH CHIROPRACTIC

146 WALNUT ST.
LAWRENCEBURG, IN 47025
(812) 537-7777
(812) 537-7094 fax
SHANNON W. BARGER, DC

CASE NO. _____

Please fill out the following form in as much detail as possible. ***(Please print)***

Name _____ Date_____
Address_____ City_____ St.___ Zip_____
Home Phone_(___)_____ Alternate Phone_(___)_____
E-mail Address_____ Would you like to receive newsletter? Y N
Age____ Date of Birth_____ Occupation_____ Sex (M)___(F)___
How did you hear about us? _____
Married(___) S(___) W(___) D(___) Children____ Name of Spouse _____
Is any other member of your family being treated in this office? _____
Have you ever had Chiropractic or Acupuncture care before?_____
For what problem? _____
Previous Chiropractor(s) or Acupuncturist(s) name / location:_____

PRESENT COMPLAINT

Major complaints and symptoms — please be as specific as you can.

1._____
2._____
3._____
4._____

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

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? _____
What positions or activities relieve your condition? _____

Have you ever been treated by a Medical Physician for this ailment?_____
Where? _____
Family physician's name _____
Please send a report to my family physician. Yes____ No ____

Have you been treated for any health condition by a physician in the past year?
If yes, what condition? _____
Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc.
(even as a child)? _____ When? _____
Have you ever broken any bones? (fractures) _____ Any dislocations? _____
What operations have you had? _____ Year _____
_____ Year _____
_____ Year _____
Give dates you have had any of the following? (if exact date is unknown, give approximate)
Blood tests _____ Urinalysis _____
MRI _____ CT Scan _____ Ultrasound _____
X-Ray examination _____
Other special treatment _____
At what hospital or office were these tests taken _____

REVIEW OF SYSTEMS

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	PAST		NOW	PAST
Neck Pain / Stiffness	____	____	Sleeping Problems	____	____
Muscle Spasms	____	____	Loss of Smell	____	____
Sleeping Problems	____	____	Loss of Taste	____	____
Back Pain	____	____	Osteoarthritis	____	____
Rheumatoid Arthritis	____	____	High Blood Pressure	____	____
Shoulder/Arm Pain	____	____	Constipation	____	____
Pins & Needles in Arms	____	____	Heart problems	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
Knee Pain	____	____	Hemorrhoids	____	____
Leg Cramps	____	____	Chest Pains	____	____
Weakness in Arms	____	____	Diabetes	____	____
Weakness in Legs	____	____	Difficulty Urinating	____	____
Shortness of Breath	____	____	Indigestion	____	____
Depression	____	____	Vomiting	____	____
Kidney Stones	____	____	Gallbladder problems	____	____
Abdominal Pain	____	____	Incontinence	____	____
Kidney Infection	____	____	Bladder Infection	____	____
Mental Illness	____	____	Panic Attacks	____	____
Swollen Hands or Feet	____	____	Blood Clots	____	____
Stroke / TIA	____	____	Persistent Cough	____	____
Ulcers	____	____	Heartburn / Reflux	____	____

PATIENT SIGNATURE _____ DATE _____
CASE NO. _____

Do you have vertigo (dizziness)? Yes _____ No _____
Do you pass out easily (faint or loss of consciousness)? Yes _____ No _____
Do you have double vision or have you lost sight in one eye? Yes _____ No _____
Do you have any slurred speech or difficulty with speech? Yes _____ No _____
Do you have indigestion or difficulty swallowing? Yes _____ No _____
Do you have any difficulty walking/ coordination /falling? Yes _____ No _____
Do you have nausea or vomiting? Yes _____ No _____
Do you have numbness on one side of your face or body? Yes _____ No _____
Do you have any visual disturbances or rapid eye movement? Yes _____ No _____
Do you have or have you ever had difficulty in arranging words properly? Yes _____ No _____
Do you have a headache or head pain that is unlike any you have had before? Yes _____ No _____
Do you have headaches for hours or days? Yes _____ No _____
Do you have a history of stroke in your family? Yes _____ No _____
Do you have chest pain? Yes _____ No _____
Do you have any change in bowel or bladder habits? 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 a nagging cough or hoarseness? Yes _____ No _____
Do you have night sweats? Yes _____ No _____
Do you have pain in radiating into jaw or face? Yes _____ No _____
Do you have a drooping eyelid or change in your pupils? Yes _____ No _____
Do you have any ringing in your ears? Yes _____ No _____
Do you take birth control pills? Yes _____ No _____

What prescription medication are you taking if any?

[ ] High blood pressure medication
[ ] Blood thinners
[ ] Herb, vitamins, or over the counter products/ pain relievers
[ ] Other _____

_____

_____

Have you ever had cancer? Yes ____ No ____
Does you 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 ____
Condition: _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____
ALCOHOL _____ Yes or _____ No, If Yes, how much _____
HOBBIES? _____

Family History

Did you 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
( ) Seizure-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Ulcer or Stomach Problems
( ) Stroke (Please indicate age when stroke occurred, Mother _____ Father _____)
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer

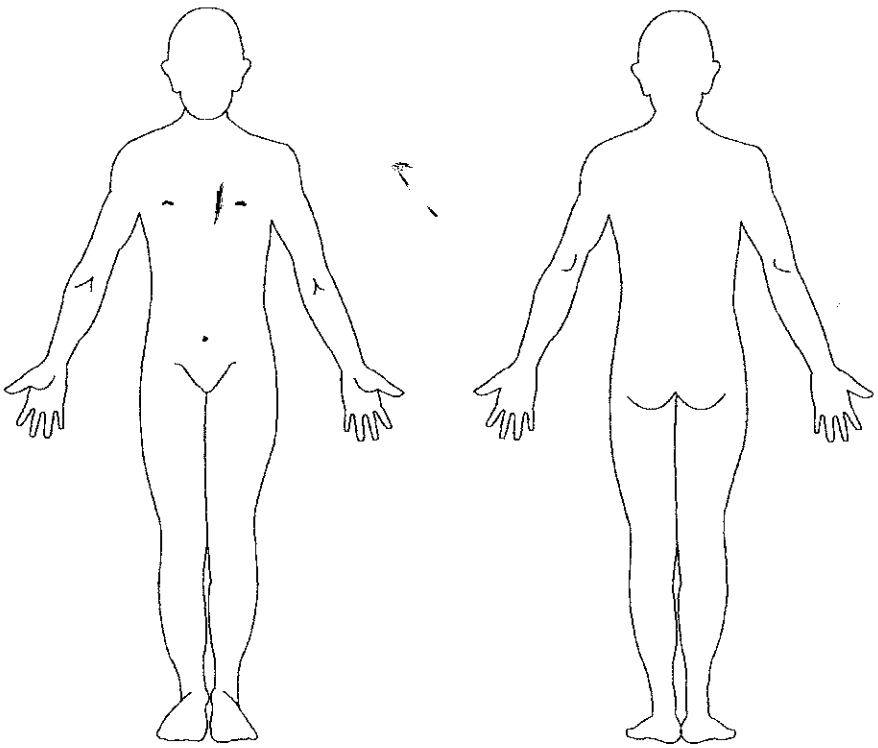
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

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
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

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 10, I rate my discomfort as follows:
(_____)
0 **10**
no pain **severe pain**

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 **10**
no pain **severe pain**

Date: _____ Signature _____ CASE NO. _____