THE BACK, NECK AND HEADACHE RELIEF CENTER AT VACAVILLE CHIROPRACTIC

YOUR CASE HISTORY

Date : _____Please Print and fill in all spaces below, if it isn't relevant to your condition please put N.A. for Not Applicable.

Name_____ Address _____

City _____State _____ Zip Code _____ Cell Phone# _____

Who is your Cell Phone Carrier (At&t, or Sprint etc.) _____ E-mail:_____

Date of Birth _____ Age _____ Height_____ Weight _____SSN _____

Occupation_____Employer_____

City you work in: _____State _____Zip code _____Work Phone:_____

Male / Female / Single / Married / Divorced , # of children _____ Name of your spouse (or parent) _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

Have you ever had Chiropractic care before? Yes / No If yes, how long ago? _____
With whom, in what Town: _____

Currently or in the past have you ever experienced any of these complaints **while working**? _____ If yes, please describe what activities at work may be causing you to experience these complaints: _____

Are there any other activities, incidents, or events **outside of work** that may have caused these complaints? _____

If yes, please explain:_____

Have you been involved in an **auto accident in the last 12 months**? Yes / No If yes, what was the date? _____

How many passengers were in the car with you? _____

List **other doctors consulted for these conditions**: 1._____ 2. _____

_____

Have you ever had any **surgeries or hospitalization**? If yes, please list: _____

_____

Please list any **injuries or illnesses** that you have had that are not listed above: _____

_____

_____

Please circle any **medications** (over-the-counter) or prescriptions you are currently taking and list any additional ones and what your take them for:

Aspirin/Tylenol, Ibuprofen, Muscle Relaxers, Pain Killers, Insulin, Tranquilizers, Birth Control Pills, Others: and their use :

_____

_____

Your Personal Health Insurance Co. Name _____ Address_____

ID Number _____ Policy Holder _____Phone Number _____

Name of Spouse's health insurance (if applicable) _____ Employer _____

Spouse's Health Insurance Claim's address_____ Policy Number _____

Please ask our staff to copy any detailed insurance cards or information you would like us to help you with:)

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.
0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 **10**

☺ Completely **able** to function ☹ Totally **unable** to function

1. **FAMILY/HOME RESPONSIBILITIES**: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.)
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

2. **RECREATION**: hobbies, sports, and other similar leisure time activities.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

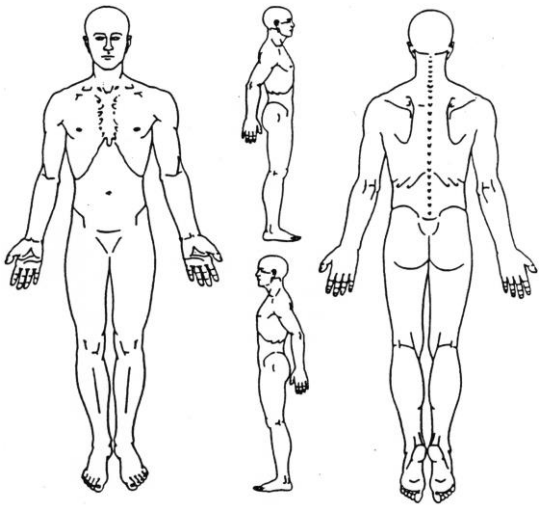
3 **SOCIAL ACTIVITY**: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

4. **OCCUPATION**: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

5. **SELF CARE**: activities that involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

6. **LIFE SUPPORT ACTIVITY**: basic life supporting behaviors such as eating, sleeping, and breathing.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

PLEASE MARK YOUR AREAS OF PAIN IN THE FIGURES BELOW.



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(707) 448-3008

Patient Signature_____**Date**_____