

KALAMAZOO COMMUNITY CHIROPRACTIC CASE HISTORY

Name _____ Date of Birth ___/___/___ Age ___

Address _____ Phone _____
Street

_____ City _____ State _____ Zip _____ Cell Phone _____

Social Security # _____ Email _____

Sex: M F Marital status: S M D W P How long? _____ # of children _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Insurance Company _____ Policy # _____ Group # _____

Primary Policyholder _____ Date of Birth ___/___/___

Address _____ Social Security # _____

Employer _____ Phone _____

Who referred you? _____

CHIEF COMPLAINT TODAY _____

Are your present injuries the result of an on-the-job injury? Yes No

Have you made a report of the accident to your employer? Yes No

Do you plan on turning it in to Workers Compensation? Yes No

Are you now or have you ever been disabled (service or work) Yes No

If yes, when _____ (date/year) How? _____

Past Chiropractic care Yes No When _____ Dr.'s Name _____

Results of care _____

Date of last exam:

Spinal _____

Disc _____

Lab _____

Physical _____

X-ray _____

Please list any accidents **EVER**:

Motor vehicle _____

Falls _____

Sports _____ Other _____

Broken bones or dislocations: _____

Ever been on crutches? Yes No Spinal taps or injections? Yes No

Ever been knocked unconscious? Yes No Ever had lapse of memory? Yes No

Ever had x-rays, MRI or CT scan? Yes No When _____

Why? _____

Are you presently taking any medication - prescription or patent? If so, what drugs?

Do you suffer from any condition other than that for which you are now consulting us? Yes No

If YES, what is it? _____

HABITS AND EXERCISE:

___ Smoking ___ packs/day Exercise program _____

___ Alcohol ___/week _____

___ Coffee ___/cups/day Please advise Dr. Kudlas of controlled substance use, if any.

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back	Weight	Alcohol
Mother	_____						
Father	_____						
Brother(s)	_____						
Sister(s)	_____						
Others	_____						

Please mark each of the following symptoms: **1** if you have **never** had it
2 if you have had the problem **previously**
3 if you have the problem **now/recently**

GENERAL <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Convulsions <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness/pain arms/legs/hands <input type="checkbox"/> Allergy <input type="checkbox"/> Wheezing <input type="checkbox"/> Neuralgia MUSCLES & JOINTS <input type="checkbox"/> Weakness <input type="checkbox"/> Twitching <input type="checkbox"/> Stiff neck <input type="checkbox"/> Backache <input type="checkbox"/> Swollen joints <input type="checkbox"/> Tremors <input type="checkbox"/> Foot trouble <input type="checkbox"/> Painful tailbone <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Spinal curvature <input type="checkbox"/> Hernia	GASTRO-INTESTINAL <input type="checkbox"/> Poor appetite <input type="checkbox"/> Poor digestion <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Belching or gas <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Pain over stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Colon trouble <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver trouble <input type="checkbox"/> Jaundice <input type="checkbox"/> Gall bladder trouble CARDIO-VASCULAR <input type="checkbox"/> Rapid Heart <input type="checkbox"/> Slow heart <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Pain over heart <input type="checkbox"/> Heart trouble <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Poor circulation <input type="checkbox"/> Varicose veins <input type="checkbox"/> Stroke <input type="checkbox"/> Cold hands/feet	RESPIRATORY <input type="checkbox"/> Chronic cough <input type="checkbox"/> Spitting blood <input type="checkbox"/> Phlegm <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty breathing GENITO-URINARY <input type="checkbox"/> Frequent urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney infection <input type="checkbox"/> Bed wetting <input type="checkbox"/> Inability to control urine <input type="checkbox"/> Prostate trouble SKIN/ALLERGIES <input type="checkbox"/> Skin eruptions <input type="checkbox"/> Itching <input type="checkbox"/> Bruising easily <input type="checkbox"/> Dryness <input type="checkbox"/> Boils <input type="checkbox"/> Hives <input type="checkbox"/> Sensitive skin <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis	ENT <input type="checkbox"/> Poor vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Pain in eyes <input type="checkbox"/> Deafness <input type="checkbox"/> Earache <input type="checkbox"/> Ear Noises <input type="checkbox"/> Ear discharges <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hay fever <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent colds <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Sinus trouble FOR WOMEN ONLY <input type="checkbox"/> Painful periods <input type="checkbox"/> Excessive flow <input type="checkbox"/> Irregular cycles <input type="checkbox"/> Hot flashes <input type="checkbox"/> Cramps <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Miscarriage <input type="checkbox"/> PMS <input type="checkbox"/> Pregnant Date of last pap test:
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Please mark **1, 2, or 3** (as above) if you have had any of the following diseases, procedures, conditions:

<input type="checkbox"/> Addiction	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental disorder	<input type="checkbox"/> Sinus
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Mercury fillings	<input type="checkbox"/> Stomach trouble
<input type="checkbox"/> Anemia	<input type="checkbox"/> EBV/mono	<input type="checkbox"/> Migraine	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Fibroid tissue	<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Toxic exposure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tubes in ears
<input type="checkbox"/> Caesarean delivery	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaccinations
<input type="checkbox"/> CFIDS	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Rectal surgery	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Root canal	<input type="checkbox"/> Other (please describe)
<input type="checkbox"/> Depression	<input type="checkbox"/> Measles		

I hereby authorize Dr Kudlas to treat my condition as he deems appropriate through the use of adjustments throughout my spine and supportive procedures. It is understood and agreed that the amount paid to the doctor for x-rays is for examination only and that the x-ray negatives remain the property of this office, being kept on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed condition known to the patient but not revealed to the doctor on this form nor for any medical diagnosis or treatment.

AUTHORIZED SIGNATURE _____

DATE _____