

YOUR CASE HISTORY:

NAME: _____ AGE: _____ Date of Birth: _____ Today's Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Sex: M F Marital Status: S M W D Social Security #: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Email Address: _____ @ _____ Who referred you to Dr. Zabrosky? _____

INSURANCE: If you wish us to file your insurance the following information must be complete:

Please be sure to give us your insurance card.

Is this a PPO? Y N HMO? Y N Are you the primary insured? (is the policy under your name?) Y N

If "No" Please provide the following information:

Insured's Name: _____ Date of Birth: _____ Relationship: _____

Employer: _____ Social Security #: _____

Do you have secondary coverage? Y N If yes, Insurance Company: _____

Insured's Name: _____ Date of Birth: _____ Relationship: _____

Employer: _____ Social Security #: _____

Where is your pain or problem?	When was your most recent onset of this problem?	Have you had this before? If yes, When?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Are your present problems due to an Accident or Injury? Yes No
 If yes, On the Job Auto Accident Other: _____

Has this been reported? Y N To Employer Your Auto Insurance Other: _____

Have you seen a chiropractor in the past? Y N For the same thing? _____ When? _____

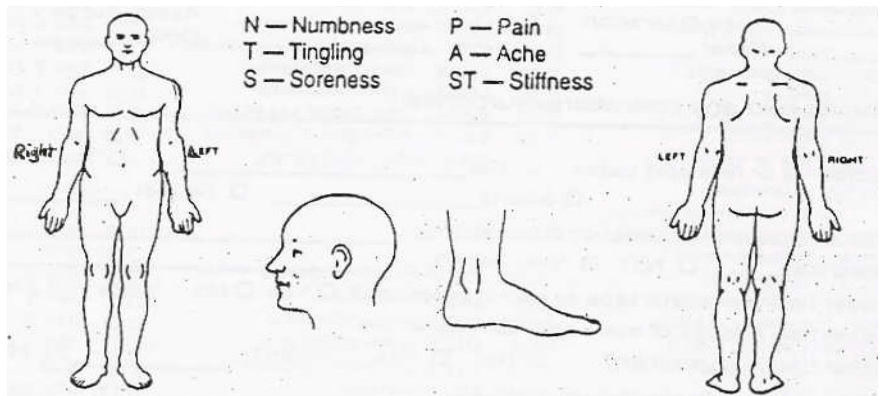
Dr.'s Name: _____ Results: _____

On the diagrams at right:

*Answer the following AFTER you have printed this form.

Please circle each area in which you are having any trouble.
 Next to each circle, please indicate the type of symptom you are having in that area, using the letter codes given.

*NOTE: If you choose to email this form, you may complete this picture at your office visit.



Please provide the following information about yourself: (If the item does not apply to you, please mark N/A)

Spouse's name: _____ Occupation _____ Employer: _____

Number of children: _____

Have you seen a Doctor for ANY reason in the past year? Y N

If yes, please describe incident, give Doctor's name and describe the results of your care: _____

HABITS	EXERCISE	FAMILY HISTORY					
<input type="checkbox"/> Smoking Packs/day _____	<input type="checkbox"/> None		Diabetes	Heart	Kidney	Cancer	Back
<input type="checkbox"/> Drinking Alcohol Frequency _____	<input type="checkbox"/> Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coffee Cups/day _____	<input type="checkbox"/> Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

General Health Information

Please complete all information, whether or not you suspect it is directly related to the issue which brings you here today.

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

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

Please check the correct box for each item below.

- | | | | |
|---|--|--|---|
| <p style="text-align: center;">GENERAL SYMPTOMS</p> <input type="checkbox"/> <input type="checkbox"/> 995.3 Allergy (What)

<input type="checkbox"/> <input type="checkbox"/> 491 Bronchitis
<input type="checkbox"/> <input type="checkbox"/> 780.9 Chills
<input type="checkbox"/> <input type="checkbox"/> 780.3 Convulsions
<input type="checkbox"/> <input type="checkbox"/> 780.4 Dizziness
<input type="checkbox"/> <input type="checkbox"/> 780.2 Fainting
<input type="checkbox"/> <input type="checkbox"/> 780.7 Fatigue
<input type="checkbox"/> <input type="checkbox"/> 780.6 Fever
<input type="checkbox"/> <input type="checkbox"/> 784.0 Headache
<input type="checkbox"/> <input type="checkbox"/> 780.52 Loss of Sleep
<input type="checkbox"/> <input type="checkbox"/> 783 Loss of Weight
<input type="checkbox"/> <input type="checkbox"/> 799.2 Nervousness
<input type="checkbox"/> <input type="checkbox"/> 729.2 Neuralgia
<input type="checkbox"/> <input type="checkbox"/> 780.8 Night Sweats
<input type="checkbox"/> <input type="checkbox"/> 782 Numbness or pain in arms /legs/hands
<input type="checkbox"/> <input type="checkbox"/> 786.09 Wheezing | <p style="text-align: center;">GASTRO-INTERSTITIAL</p> <input type="checkbox"/> <input type="checkbox"/> 787.3 Belching or Gas
<input type="checkbox"/> <input type="checkbox"/> 789.0 Colon Trouble
<input type="checkbox"/> <input type="checkbox"/> 564.0 Constipation
<input type="checkbox"/> <input type="checkbox"/> 558.9 Diarrhea
<input type="checkbox"/> <input type="checkbox"/> 783.6 Excessive Hunger
<input type="checkbox"/> <input type="checkbox"/> 575.9 Gall Bladder Trouble
<input type="checkbox"/> <input type="checkbox"/> 455.6 Hemorrhoids (Piles)
<input type="checkbox"/> <input type="checkbox"/> 782.4 Jaundice
<input type="checkbox"/> <input type="checkbox"/> 794.8 Liver Trouble
<input type="checkbox"/> <input type="checkbox"/> 787.0 Nausea
<input type="checkbox"/> <input type="checkbox"/> 536.8 Pain over Stomach
<input type="checkbox"/> <input type="checkbox"/> 783.0 Poor Appetite
<input type="checkbox"/> <input type="checkbox"/> 536.8 Poor Digestion
<input type="checkbox"/> <input type="checkbox"/> 787.0 Vomiting
<input type="checkbox"/> <input type="checkbox"/> 578.0 Vomiting Blood | <p style="text-align: center;">EYE/EAR/NOSE/THROAT</p> <input type="checkbox"/> <input type="checkbox"/> 493.9 Asthma
<input type="checkbox"/> <input type="checkbox"/> 378.9 Crossed Eyes
<input type="checkbox"/> <input type="checkbox"/> 389.9 Deafness
<input type="checkbox"/> <input type="checkbox"/> 388.70 Earache
<input type="checkbox"/> <input type="checkbox"/> 388.60 Ear Discharges
<input type="checkbox"/> <input type="checkbox"/> 388.30 Ear Noises
<input type="checkbox"/> <input type="checkbox"/> 240.9 Enlarged Thyroid
<input type="checkbox"/> <input type="checkbox"/> 460 Frequent Colds
<input type="checkbox"/> <input type="checkbox"/> 477.9 Hay Fever
<input type="checkbox"/> <input type="checkbox"/> 784.49 Hoarseness
<input type="checkbox"/> <input type="checkbox"/> 478.1 Nasal Obstruction
<input type="checkbox"/> <input type="checkbox"/> 784.7 Nose Bleeds
<input type="checkbox"/> <input type="checkbox"/> 379.91 Pain in Eyes
<input type="checkbox"/> <input type="checkbox"/> 368.9 Poor Vision
<input type="checkbox"/> <input type="checkbox"/> 473.9 Sinusitis
<input type="checkbox"/> <input type="checkbox"/> 462 Sore Throats
<input type="checkbox"/> <input type="checkbox"/> 463 Tonsillitis | <p style="text-align: center;">RESPIRATORY</p> <input type="checkbox"/> <input type="checkbox"/> 786.50 Chest Pain
<input type="checkbox"/> <input type="checkbox"/> 786.2 Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> 786.09 Difficulty Breathing
<input type="checkbox"/> <input type="checkbox"/> 786.3 Spitting Blood
<input type="checkbox"/> <input type="checkbox"/> 786.4 Spitting Phlegm

<p style="text-align: center;">GENITO-URINARY</p> <input type="checkbox"/> <input type="checkbox"/> 788.3 Bed Wetting
<input type="checkbox"/> <input type="checkbox"/> 599.7 Blood in Urine
<input type="checkbox"/> <input type="checkbox"/> 788.4 Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> 788.3 Inability to Control Urine
<input type="checkbox"/> <input type="checkbox"/> 590.9 Kidney Infection
<input type="checkbox"/> <input type="checkbox"/> 788.1 Painful Urination
<input type="checkbox"/> <input type="checkbox"/> 601.9 Prostate Trouble |
|---|--|--|---|

- | | | | |
|--|---|--|---|
| <p style="text-align: center;">MUSCLES & JOINTS</p> <input type="checkbox"/> <input type="checkbox"/> 724.5 Backache
<input type="checkbox"/> <input type="checkbox"/> 719.7 Foot Trouble
<input type="checkbox"/> <input type="checkbox"/> 550.0 Hernia
<input type="checkbox"/> <input type="checkbox"/> 719.1 Pain Between Shoulders
<input type="checkbox"/> <input type="checkbox"/> 724.6 Painful Tail Bone
<input type="checkbox"/> <input type="checkbox"/> 723.9 Stiff Neck
<input type="checkbox"/> <input type="checkbox"/> 781.9 Spinal Curvature
<input type="checkbox"/> <input type="checkbox"/> 719.0 Swollen Joints
<input type="checkbox"/> <input type="checkbox"/> 781.0 Tremors
<input type="checkbox"/> <input type="checkbox"/> 781.0 Twitching
<input type="checkbox"/> <input type="checkbox"/> 728.8 Weakness | <p style="text-align: center;">CARDIO-VASCULAR</p> <input type="checkbox"/> <input type="checkbox"/> 401.9 High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> 458.9 Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> 786.51 Pain over Heart
<input type="checkbox"/> <input type="checkbox"/> 785.9 Poor Circulation
<input type="checkbox"/> <input type="checkbox"/> 438 Previous Heart Trouble
<input type="checkbox"/> <input type="checkbox"/> 785.0 Rapid Heart
<input type="checkbox"/> <input type="checkbox"/> 427.89 Slow Heart
<input type="checkbox"/> <input type="checkbox"/> 436 Strokes
<input type="checkbox"/> <input type="checkbox"/> 782.3 Swelling Ankles
<input type="checkbox"/> <input type="checkbox"/> 454 Varicose Veins | <p style="text-align: center;">SKIN OR ALLERGIES</p> <input type="checkbox"/> <input type="checkbox"/> 690 Bolls
<input type="checkbox"/> <input type="checkbox"/> 924.9 Bruising Easily
<input type="checkbox"/> <input type="checkbox"/> 701.1 Dryness
<input type="checkbox"/> <input type="checkbox"/> 691.8 Eczema
<input type="checkbox"/> <input type="checkbox"/> 708.9 Hives or Allergy
<input type="checkbox"/> <input type="checkbox"/> 698.9 Itching
<input type="checkbox"/> <input type="checkbox"/> 782.0 Sensitive Skin
<input type="checkbox"/> <input type="checkbox"/> 368.9 Skin Eruptions | <p style="text-align: center;">FOR WOMEN ONLY</p> <input type="checkbox"/> <input type="checkbox"/> 625.3 Cramps or Backaches
<input type="checkbox"/> <input type="checkbox"/> 626.2 Excessive Flow
<input type="checkbox"/> <input type="checkbox"/> 627.2 Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> 626.4 Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> 634.9 Miscarriage
<input type="checkbox"/> <input type="checkbox"/> 625.3 Painful Periods
<input type="checkbox"/> <input type="checkbox"/> 623.5 Vaginal Discharge
<input type="checkbox"/> No <input type="checkbox"/> Pregnant at this time
_____ Last Pap
Date By Whom _____ |
|--|---|--|---|

OPERATIONS AND PROCEDURES

- | | | |
|--|---|--|
| DATE _____
_____ Vaccinations
_____ Tonsillectomy
_____ Gall Bladder
_____ Back Operation
_____ Other _____ | DATE _____
_____ Tubes in Ears
_____ Appendectomy
_____ Female Organs
_____ Rectal Surgery
_____ Other _____ | DATE _____
_____ Sinus
_____ Hernia
_____ Thyroid
_____ Stomach
_____ Other _____ |
|--|---|--|

I have never had any operations/surgeries.

- List any accidents or fall and dates: _____
- Car _____ Recreational Vehicle _____
 Sports _____ School _____ Other _____

- List any broken bones (fractures) or dislocations: _____
- Ever on crutches? No Yes Why? _____
- Have you ever had any spinal taps or spinal injections? Yes No Where you ever knocked unconscious? Yes No
- Have you ever had a lapse of memory? Yes No
- Have you ever had X-rays taken? No Yes When _____ By Whom? _____
- For what ailments were these X-rays made? _____

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

Are you presently taking any medication – prescription or over-the-counter? No Yes What drugs? _____

If you have other health conditions or concerns which have not been noted above, please note them here so that Dr. Zabrosky can discuss them with you.