

Offices of Dr. Jack R. Giangiulio, DC

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CASE HISTORY

Full Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: Male or Female

Chief Complaint: 1. _____
2. _____
3. _____
4. _____

Are your present problems due to an injury? (Y) or (N) If yes, please check all of the below boxes that apply to you.

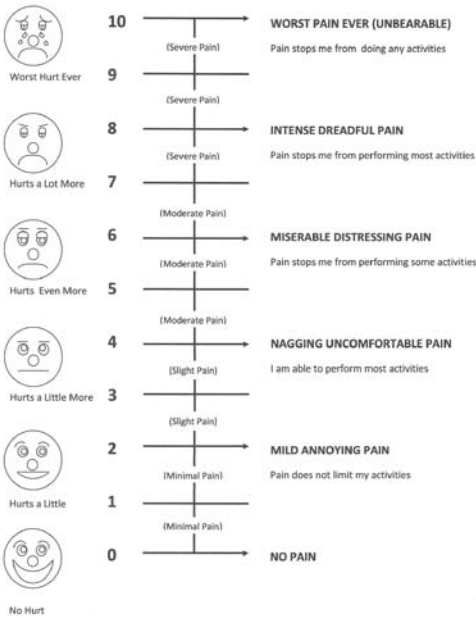
Occurred on the job Due to Auto Accident Personal Injury Case Other Reason _____

Injuries have been reported to: Employer Workers' Comp. Auto Carrier Police

Have you retained an attorney? (Y) or (N)

Are you now or have you ever been disabled? (Y) or (N) If so, when? _____

Pain Scale Key



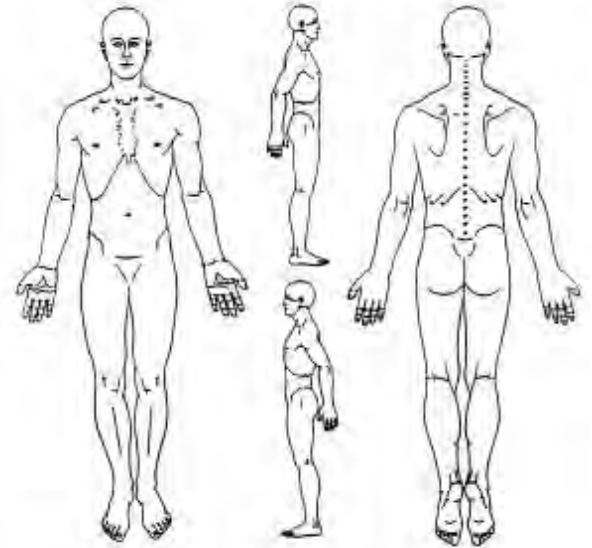
Severity of Pain

List region of pain and circle severity number (See Pain Scale Key)

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

Type of Pain Code (Mark on figure)

- +++ Burning
- 000 Stabbing
- Sharp
- ||| Tingling/numb
- AAA Achy



Please mark areas of pain on the figures using the code listed above

Habits

Smoking Packs/Day _____
 Alcohol Cups/Day _____
 Caffeine Cups/Day _____
 Diet Drinks Cups/Day _____
 Illegal/Rx Drugs _____

Exercise/Type

None
 Moderate
 Daily
 Dance
 Yoga / Pilates
 Weight Lifting
 Cardio/Aerobics
 Other _____

Family History

	Cancer	Diabetes	Heart	Kidney	Arthritis	Similar Problem
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sisters, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had or presently have any of the following conditions?

(Note: if you have Hepatitis, AIDS, or are HIV Positive; you must notify the doctor so he may enact the legally mandated sterilization techniques. Thank you.)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Non-listed Diseases
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	<input type="checkbox"/> Panic Attacks	_____
<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Measles	<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mental Disorder (other)	_____
<input type="checkbox"/> Polio	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Eczema		_____

(Continued on other side)

Please check the correct box for each item below. Check at least one box for each of the symptoms listed.

General Symptoms

Never Presently

Fever

Chills

Convulsions

Dizziness

Fainting

Fatigue

Loss of Sleep

Loss of Weight

Loss of Consciousness

Loss of Memory

Nervousness

Headache

Night Sweats

Numbness/Tingling in Arms/Hands/Legs/Feet

Muscles & Joints

Never Presently

Foot Trouble

Arch Pains

Hand Trouble

Neck Ache

Backache

Spinal Curvature

Stiff Neck

Tail Bone Pain

Swollen Joints

Hernia

Tremors/Twitching

Neuralgia

Weakness

Pain between Shoulder Blades

Gastro-Intestinal

Never Presently

Belching or Gas

Colon Trouble

Constipation

Diarrhea

Excessive Hunger

Gall Bladder Trouble

Hemorrhoids (Piles)

Jaundice

Liver Trouble

Nausea

Pain Over Stomach

Poor Appetite

Poor Digestion

Vomiting

Vomiting Blood

Eye/ear/Nose/Throat

Never Presently

Hay Fever (Allergies)

Poor Vision

Pain in Eyes

Crossed Eyes

Earache

Deafness

Ear Discharge

Ear Noises

Nasal Obstruction

Nose Bleeds

Sinusitis

Tonsillitis

Hoarseness

Sore Throats

Frequent Colds

Enlarged Thyroid

Cardiovascular

Never Presently

High Blood Pressure

Low Blood Pressure

Poor Circulation

Heart Troubles

Pain Over Heart

Rapid Heart Rate

Slow Heart Rate

Irregular Heart Rate

Strokes

Varicose Veins

Swollen Ankles

Respiratory

Never Presently

Asthma

Chronic Cough

Wheezing

Difficulty Breathing

Chest pain

Spitting Phlegm

Spitting Blood

Bronchitis

Genito-Urinary

Bed Wetting

Blood in Urine

Frequent Urination

Painful Urination

Kidney Infection

Prostate Trouble

Inability to Control Urine

Skin or Allergies

Never Presently

Boils

Bruising Easily

Skin Dryness

Eczema

Hives or Allergies

Itching

Sensitive Skin

Skin Eruptions

Allergies

(Please all list below)

For Women Only

Never Presently

Cramps or Backaches

Excessive Flow

Hot Flashes

Irregular Cycle

Painful Periods

Vaginal Discharge

Pregnant

Miscarriage

Last Gyno-Exam Date _____

Last Pap Smear Date _____

Last Breast Exam Date _____

Operations and Procedures

<u> </u> Date or Age	<u> </u> Date or Age	<u> </u> Date or Age	<u> </u> Date or Age
<u> </u> Vaccinations	<u> </u> Gall Bladder	<u> </u> Breast Augmentation	<u> </u> Abdominal Surgery
<u> </u> Tonsillectomy	<u> </u> Appendectomy	<u> </u> Neck Surgery	<u> </u> Cesarean Section
<u> </u> Oral Surgery	<u> </u> Rectal Surgery	<u> </u> Back Surgery	<u> </u> Spinal Injects/Taps
<u> </u> Tubes in Ears	<u> </u> Hernia	<u> </u> Sinus Surgery	<u> </u> Other _____
<u> </u> Thyroid	<u> </u> Female Organs	<u> </u> Face Lift	<u> </u> Other _____

I have never had any operations/surgeries.

List and Date all Hospitalizations (other than the above): _____

List and date any accidents or falls: Dance/Sports _____

Vehicular _____ Other _____

List and date any fractures or dislocations: _____

List and date all X-Ray, MRI, CAT Scan and Bone Scan (Please indicate what ailments they were for.): _____

Are you presently using any prescription or over-the-counter medicines or vitamins? (Y) or (N) If yes, please list below.

Do you suffer from any conditions other than that for which you are consulting us? (Y) or (N) If yes, please list below.

As evidence by my below signature, I have completed this form to the best of my knowledge and I fully understand that I am seeking a chiropractic consult and that I will not hold this Doctor of Chiropractic responsible for any pre-existing medically diagnosed conditions nor for the diagnosis of any medical conditions.

Patient's/Guardian's Signature

Printed Name

Date