



CHIROPRACTIC & ACUPUNCTURE MEDICAL CENTER

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Thomas T. Mang, D.C., P. A.
Chiropractic Physician

Trieu N. Ngo, D.C.
Chiropractic Physician

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Chiropractic Physician

CASE HISTORY

Name _____ Age _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
 Social Security # _____ Driver's License # _____
 Occupation Employer _____ Phone (Work) _____
 Insurance Company _____ Phone _____
 Insured's Name _____ Insured's Date of Birth _____
 Insured's ID. # or S.S. # _____
 Spouse's Name _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Phone (Work) _____
 Spouse's Insurance Co. _____ Phone _____
 Spouse's Social Security # _____
 Present condition due to an injury? ___ Yes ___ No ___ On the Job ___ Auto Accident ___ Other _____
 Has the accident been reported? ___ Yes ___ No ___ To Employer ___ Auto Carrier ___ Other _____

HEALTH REPORT:

Reason for seeking care: _____
 List any other doctors seen for this: _____
 List any diagnosis and type of treatment: _____
 Have you had similar accidents or injuries before? ___ Yes ___ No If yes, explain: _____
 List the names of any relatives that have or have had a similar problem: _____
 Have you or any relative received chiropractic treatment previously? ___ Yes ___ No
 If yes, explain: _____
 Have you been treated for any health condition by a physician in the last year? ___ Yes ___ No
 If yes, explain: _____
 Are you currently taking medication? ___ Yes ___ No list medications: _____

 Have you taken medication in the past? ___ Yes ___ No list medications _____
 List conditions you are taking medications for: _____
 List the approximate dates of any surgery or treated conditions: _____

Family History: Health conditions, age of death and cause of death.

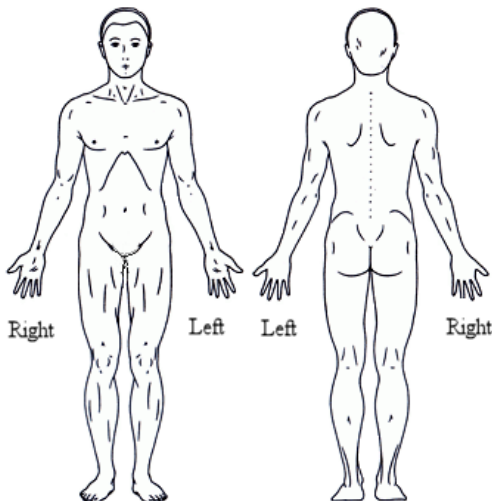
Father: _____
 Mother: _____
 Brother/s & Sister/s: _____
 Do you smoke ___ Y ___ N •Alcohol ___ Y ___ N ___ Daily ___ Weekly ___ Social Occasions •Caffeinated drinks per day ___
 Do you take Vitamins/Supplements ___ Y ___ N If yes, type and how often _____

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

- Numbness = = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing / / /
- Pins, Needles + + +
- Other ^ ^ ^



What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is this condition worse during certain times of the day? ___ Y ___ N
 Is this condition interfering with Work? _____
 Sleep? _____ Routine? _____ Other? _____
 Is this condition progressively getting worse? _____

Patient Name: _____ Date: _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____