MANG CHIROPRACTIC

2040A PUBLIC SQUARE COURT
NORTH BEND OR 97459
PHONE: (541) 756-0525 DR. CALVIN E MANG DC PC FAX: (541) 756-8428

REQUIRED FOR YOUR CASE HISTORY

NAME:(LAST, FIRST ,MIDDLE)____DATE____________________________

ADDRESS:____
CITY, STATE, ZIP

PHONE NO.(_____)__________________________DRIVERS LICENSE #/STATE.________________________ SSN: ________________________________

AGE_________ DATE OF BIRTH__________________________ HEIGHT__________ WEIGHT __________

CIRCLE IF YOU ARE: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

EMPLOYER:____POSITION:____

ADDRESS:____PHONE NO.(______)___________________________

EMAIL ADDRESS:____

NAME OF SPOUSE:____EMPLOYER:____

NEAREST RELATIVE (NOT LIVING WITH YOU)____

PHONE NO.(____)__________________________ ADDRESS____

WHO MAY WE THANK FOR REFERRING YOU:____

THE HUMAN BODY IS DESIGNED TO BE HEALTHY. THROUGHOUT LIFE, EVENTS OCCUR WHICH DAMAGE YOUR HEALTH EXPRESSION. THIS CASE HISTORY WILL UNCOVER THE LAYERS OF DAMAGE, ESPECIALLY TO YOUR NERVOUS SYSTEM, THAT RESULTED IN POOR HEALTH. FOLLOWING YOUR EXAM, YOUR CHIROPRACTOR WILL OUTLINE A COURSE OF CARE TO BEGIN TO CORRECT THESE LAYERS OF DAMAGE AND RECOVER YOUR INNATE HEALTH POTENTIAL.

IN THE PAST-HAVE YOU EVER SUFFERED FROM: CIRCLE YOUR ANSWERS

Dizziness	yes	no	Neuritis	yes	no	Backaches	yes	no	Digestive disorders	yes	no
Heart trouble	yes	no	Nervousness	yes	no	Diabetes	yes	no	Sinus troubles	yes	no
Tuberculosis	yes	no	Rheumatic Fever	yes	no	Arthritis	yes	no	Anemia	yes	no
Headaches	yes	no	Cancer	yes	no	Numbness	yes	no	Kidney troubles	yes	no
Lung problems	yes	no	Hospitalization	yes	no	Aids or HIV	yes	no	Heartburn	yes	no
Ulcers	yes	no	Menstrual Pain	yes	no	Menstrual Issues	yes	no			

Please Explain
____

____

HAVE YOU EVER HAD CHIROPRACTIC CARE ?____

DATE OF LAST PHYSICAL EXAMINATION?____

FAMILY HISTORY OF: HEART DISEASE CANCER DIABETES ARTHRITIS BACK PROBLEMS OTHER_________________________

WOMEN ONLY: MENSTRUAL PROBLEMS___________________OTHER FEMALE PROBLEMS____

NO. OF CHILDREN:____________ NO. OF PREGNANCIES:___________ MISCARRIAGES:________ ABORTIONS:___________

HAVE YOU EVER HAD: SURGERY FRACTURES CAR ACCIDENTS FALLS ON-JOBS INJURY

DESCRIBE:____

____

MANG CHIROPRACTIC
2040A PUBLIC SQUARE COURT
NORTH BEND OR 97459
PHONE: (541) 756-0525 DR. CALVIN E MANG DC PC FAX: (541) 756-8428

ON A SCALE OF POOR, GOOD, EXCELLENT PLEASE DESCRIBE YOUR:
DIET_________________ EXERCISE_________________ SLEEP_________________GENERAL HEALTH_________________

What medications are you currently taking? ____

PRESENT HISTORY (what finally caused you to make an appointment?)
Major symptom: ____

____

Symptoms began:______-______-______ from injury or gradual onset.________________________________
CIRCLE ONE

Have you had any of these symptoms in the last month?

( ) Headaches ( ) Fainting ( ) Neck Pain ( ) Diarrhea ( ) Tension ( ) Pins & Needles in Arms
( ) Loss of Smell ( ) Fatigue ( ) Loss of Taste ( ) Back Pain ( ) Cold Feet ( ) Pins & Needles in Legs
( ) Irritability ( ) Chest pain ( ) Constipation ( ) Fever ( ) Stomach Upset ( ) Lights Bother Eyes
( ) Dizziness ( ) Loss of Memory ( ) Cold Sweats ( ) Neck Stiff ( ) Face Flushed ( ) Problem Urinating
( ) Depression ( ) Loss of Balance ( ) Ears Ring ( ) Buzzing in Ears ( ) Nervousness ( ) Sleeping Problems
( ) Mood Swings ( ) Short of Breath ( ) Numbness in toes ( ) Cold Hands ( ) Hot Flashes ( ) Head Seems too Heavy
( ) Numbness in Finger

If you are experiencing pain, is it.....
☐ Sharp ☐ Dull ☐ Intermittent (comes and goes) ☐ Travels ☐ Constant

Since the problem started, it's... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? What makes it better?
____

Yes, it interferes with:
☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Is the condition worse in the:
☐ Morning ☐ Afternoon ☐ Evening ☐ When first go to bed ☐ After in bed for couple hours ☐ Before I get out of bed

Have you tried:
☐ Moist Heat ☐ Ice ☐ Electric Heating Pad ☐ Alternating Hot & Cold Packs ☐ Other At Home Remedies

MANG CHIROPRACTIC
2040A PUBLIC SQUARE COURT
NORTH BEND OR 97459
PHONE: (541) 756-0525 DR. CALVIN E MANG DC PC FAX: (541) 756-8428

Have you seen another doctor for this? ____

Do you want a copy of your privacy notice? Yes No Initials____________

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY CHIROPRACTIC SERVICES RENDERED.

Signature:____ Date:__________________________

(M E D H S T 6- 2013/ MED FORMS)