Greetings,

Welcome to Casab Sports & Wellness Chiropractic! My goal is to heighten peoples' desire to pursue the life they want to live through natural health care for the whole body and education.

I want to fully understand your unique situation and take the time to help you achieve your goals. I have spent the better part of my life being completely fascinated with the human body and how it functions. With that desire to know everything I could about the body, I received my BS in Biology (Systems Physiology) and a minor in Chemistry from San Jose State. I then went on to receive my DC from Palmer – West. With over 8 years of academic and clinical training, as well as numerous outside seminars, I am well equipped to provide you with the level of care you should expect and deserve.

I have always been very athletic. Weight training, running, hiking, and competitive equestrian riding are just a few of the sports and activities that have interested me over the years. This desire to remain active allows me the ability to understand the mindset of the athlete and the constant desire to function at their best. Yet, it was not athletics that ultimately drove me to become a chiropractor. At the age of 12, I began having a lot of pain caused by daily muscle spasms throughout my back. These spasms numbed the surface of my back permanently within 6 months. I went to multiple doctors who could not figure out what was wrong and tried to place me on prescription pain medication, potentially for the rest of my life. Considering I was only 13, I was unhappy with that idea. I decided there had to be another way, but it was not until much later that I found it. At the age of 20, my riding trainer encouraged me to have my horse seen by a chiropractor that changed his life and body overnight. Regrettably, I was not willing to spend the money on a chiropractor for myself. All my money went to my horses. Finally, 2 years later that same trainer told me I was no longer allowed to compete until I was adjusted, so I received my first adjustment. That night I was able to feel water hit my back for the first time in 10 years! It was the most amazing feeling I have ever felt, an absolutely indescribable feeling, and all because of Chiropractic!

That sense of how amazing the world can be when things are working correctly in our body is what I want to return to all of my patients. Whether, it is the athlete who was injured or the person down the street that just wants to live a better, pain free life. The realm of modern medicine as it stands is based on treating the symptoms, typically with prescription medications, not the underlying cause. That is where I come in. My willingness to thoroughly investigate all of your health concerns is designed to discover the cause of your imbalance, rather than simply covering up your symptoms. You can consider me your primary doctor for all non-emergency conditions and always know that I will do everything in my power to help you achieve your health goals.

Sincerely,

Dr. Jacklyn Casab DC

Patient Information

Patient Title: *(check one)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

Name _____ Sex _____

Address _____

City _____ State ____ Zip Code _____

Primary phone _____ Cell phone _____

Email address _____

Birth date _____ Age _____ Marital Status ☐ S ☐ M ☐ W ☐ D

In case of emergency, whom should we contact? _____ Phone:_____

How did you hear about our office? _____

Have you ever seen a chiropractor before? ☐ Y ☐ N

If yes, which doctor? _____ Where? _____

Occupation _____ Employer _____

Please rank and briefly describe your current complaints. This can include chronic pain and/or injuries.

_____

_____

_____

Please describe your current health goals for seeing Dr. Casab

_____

_____

Is this condition a result of an injury that occurred at work, in a motor vehicle accident, or a manner that may result in a legal dispute? ☐ Y ☐ N

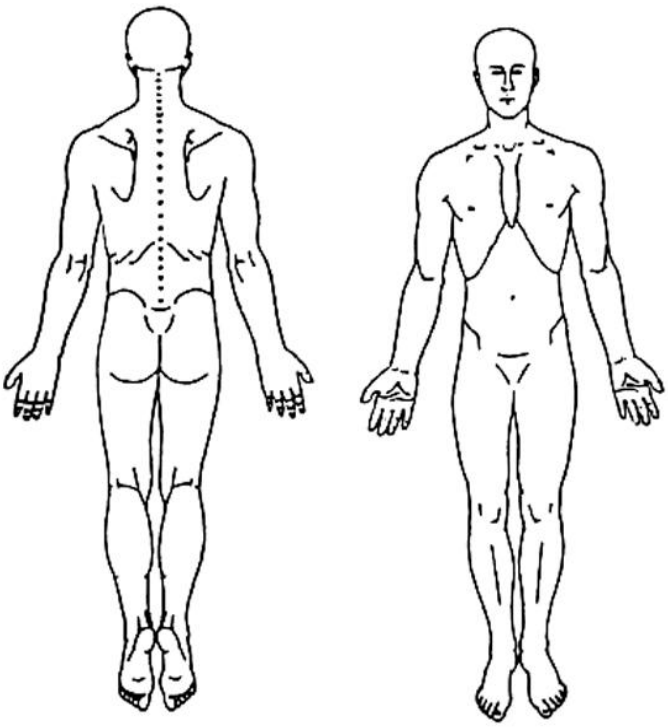
Are you currently doing anything that makes the condition better or worse? _____

_____

Have you received treatment in the past for this condition? _____ What was the treatment and did it help? _____

_____

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can write additional notes if a description would be helpful. Then, please answer the questions to the right by circling the number that best represents your pain, where 0 = no pain and 10 = the worst pain you can imagine.



Scars: Use the diagrams to the left to draw any scars that you have.

Rate your pain at its WORST in the past 24 hours from 1-10.

1 2 3 4 5 6 7 8 9 10

Rate your pain at its BEST in the past 24 hours from 1-10.

1 2 3 4 5 6 7 8 9 10

Rate your pain on AVERAGE for the past week from 1-10.

1 2 3 4 5 6 7 8 9 10

Allergies

List any known allergies to medication _____

List any other known allergies including food allergies, environmental, and seasonal _____

_____

Smoking History

Do you currently smoke? _____ How much? _____ How long? _____

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very interested*

Surgeries/Hospitalizations

	Date	Procedure (eg. knee repair)	Description	
1				In Patient/Out Patient
2				In Patient/Out Patient
3				In Patient/Out Patient
4				In Patient/Out Patient
5				In Patient/Out Patient

Medications and Supplements

Please list all medications, herbs or supplements currently taken either regularly or on an occasional basis

	Medication/Herb/ Supplement name	**Quantity/Dosage** (ie. 1 tablet / 5mg)	**Regularly or occasionally**	**If regularly, Frequency** (ie. 2 times / day)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Social History

Education: Are you currently a student? ☐ Y ☐ N

If yes, are you ☐ full-time ☐ Part-time

Mark the highest level of education completed

☐ Elementary school ☐ Middle school ☐ High school ☐ Vocational ☐ GED

☐ Associates degree ☐ Bachelors Degree ☐ Graduate Degree ☐ Doctorate ☐ Other

Work Activity: What is your job title/description? _____

What do you do most of the day at work?

☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy Labor ☐ Other

How would you describe the physical stress level at work?

☐ Low ☐ Medium ☐ High

How many hours/day do you work? _____ How many days/week? _____

What job did you do during most of your life? _____

Health Evaluation

What is your current energy level? *(circle one)* 1 2 3 4 5 6 7 8 9 10

How is your sleep quality? *(please check all that apply)*

☐ Restless ☐ Restful ☐ Hard to get to sleep ☐ Wake up often ☐ Nightmares

In what position do you typically sleep? _____

What time do you usually fall asleep? _____ How long do you sleep on average? _____

Do you exercise regularly? ☐ Y ☐ N How many days/week? _____How many minutes/day _____

What type of exercise(s) do you do? _____

How do you spend your spare time (hobbies, etc.)? _____

How would you rate your physical stress level? *(circle one)* 1 2 3 4 5 6 7 8 9 10

List your major physical stressors _____

How would you rate your emotional stress level? 1 2 3 4 5 6 7 8 9 10

List you major emotional stressors (work, relationships, health concerns, fears, etc.)?

_____

Diet & Nutrition

Are you on any special diet? ☐ Y ☐ N If yes, for what reason? _____

Is your weight a concern for you emotional or physically? ☐ Y ☐ N

Have you gained or lost over 10 pounds in the past 6 months without wanting to? ☐ Y ☐ N

How would you describe your diet?
☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted

How many 8 ounce glasses of water do you drink per day? _____

For each of the items below check whether you consume them and indicate how often (ie. 2 cups/day)
☐ Coffee/tea _____ ☐ Soda _____ ☐ Alcohol _____
☐ Fast food _____ ☐ Recreational drugs _____

Personal Health history

Are you currently under the care of a Healthcare Provider or any other doctor? ☐ Y ☐ N

Provider's Name(s) & phone numbers _____

Are there any goals or issues you are presently addressing with any member of your medical team (general health, medical conditions/allergies, etc.)?

_____

Please list any car accidents you were in and when

_____

_____

Indicate any injuries you have sustained and the date below:

☐ Back injury _____ ☐ Fall (severe) _____ ☐ Laceration (severe) _____
☐ Broken bones _____ ☐ Fracture _____ ☐ Soft tissue injury _____
☐ Concussions_____ ☐ Head Injury _____ ☐ Spinal/Disc injury _____
☐ Disability (ies) _____ ☐ Joint injury _____ ☐ Other _____

Review of Systems

Please check the "Now" box for all conditions that you are currently experiencing and mark the "Past" box for any condition or symptoms experienced at any time in your life.

	Now	Past
General		
Weight loss	☐	☐
Weight gain	☐	☐
Head		
Blacking out	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Headache	☐	☐
Head trauma	☐	☐
Vertigo	☐	☐
Eyes		
Cataracts	☐	☐
Changes in vision	☐	☐
Excessive tearing	☐	☐
Flashes in vision	☐	☐
Light sensitivity	☐	☐
Spots in vision	☐	☐
Mouth		
Bleeding gums	☐	☐
Changes in taste	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Dry mouth	☐	☐
Hoarseness	☐	☐
Jaw pain	☐	☐
Lymphadenopathy	☐	☐
Sore throat	☐	☐
Ears		
Hearing problems	☐	☐
Sensitivity to sound	☐	☐
Tinnitus	☐	☐
Nose		
Discharge	☐	☐
Nosebleeds	☐	☐
Sinus problems	☐	☐
Lungs		
Asthma	☐	☐
Coughing blood	☐	☐
Coughing phlegm	☐	☐
Difficulty breathing	☐	☐
Persistent cough	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Wheezing	☐	☐
Cardiovascular		
Ankle swelling	☐	☐
Calf pain	☐	☐
Chest pain	☐	☐
Cold hands/feet	☐	☐
High blood pressure	☐	☐
Intermittent claudication	☐	☐
Leg cramps	☐	☐
Low blood pressure	☐	☐
Orthopnea	☐	☐
Palpitations	☐	☐
Paroxysmal nocturnal dyspnea	☐	☐
Varicose veins	☐	☐
G-I System		
Abdominal pain	☐	☐
Blood in stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Food intolerance	☐	☐
Gall bladder disease	☐	☐
Gas	☐	☐
Heartburn	☐	☐
Hemorrhoids	☐	☐
Indigestion	☐	☐
Liver disease	☐	☐
Ulcers	☐	☐
Trouble swallowing	☐	☐
Vomiting/Nausea	☐	☐
Urinary Tract		
Blood in urine	☐	☐
Decreased urination	☐	☐
Difficulty urinating	☐	☐
Dribbling	☐	☐
Foul odor of urine	☐	☐
Incontinence	☐	☐
Increased urination	☐	☐
Kidney stones	☐	☐
Nocturia	☐	☐
Painful urination	☐	☐
Urgency	☐	☐
Urinary infection	☐	☐
Female		
Abnormal bleeding	☐	☐
Breast lump/pain	☐	☐
Cramps	☐	☐
Dysmenorrhea	☐	☐
Hormone therapy	☐	☐
Menopausal symptoms	☐	☐
Nipple discharge	☐	☐
Post-menopausal bleeding	☐	☐
Vaginal discharge	☐	☐
Vaginal itching	☐	☐
Vaginal lumps	☐	☐
Vaginal sores	☐	☐
Difficult/painful sexual intercourse	☐	☐
Male		
Erectile dysfunction	☐	☐
Penile discharge	☐	☐
Penile/testicular lumps	☐	☐
Penile/testicular lesions	☐	☐
Penile/testicular sores	☐	☐
Prostate problems	☐	☐
Testicular pain	☐	☐
Neurological		
Difficulty walking	☐	☐
Numbness/loss of sensation	☐	☐
Paralysis	☐	☐
Paresis	☐	☐
Poor coordination	☐	☐
Seizures/Epilepsy	☐	☐
Strokes	☐	☐
Tingling sensations	☐	☐
Tremor/Involuntary movements	☐	☐
Muscle/Bone		
Arthritis	☐	☐
Bone pain	☐	☐
Dislocations	☐	☐
Fractures	☐	☐
Joint pain	☐	☐
Limitation of motion	☐	☐
Muscle ache/pain	☐	☐
Stiffness	☐	☐
Tenderness	☐	☐
Skin		
Brittle nails	☐	☐
Bruising	☐	☐
Change in hair/nails	☐	☐
Changes in moles or cysts	☐	☐
Dryness	☐	☐
Itching	☐	☐
Lumps	☐	☐
Peeling	☐	☐
Rash	☐	☐
Redness	☐	☐
Endocrine		
Change in glove / hat / shoe size	☐	☐
Cold intolerance	☐	☐
Excessive sweating	☐	☐
Excessive thirst	☐	☐
Excessive hunger	☐	☐
Goiter	☐	☐
Heat intolerance	☐	☐
Psychological		
Anxiety	☐	☐
Confusion	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Insomnia	☐	☐
Memory loss	☐	☐
Mood change	☐	☐
Childhood diseases		
Chicken pox	☐	☐
CMV	☐	☐
Measles	☐	☐
Mononucleosis	☐	☐
Mumps	☐	☐
Pneumonia	☐	☐
Respiratory syncytial virus (RSV)	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Tetanus	☐	☐
Whooping cough	☐	☐
Conditions		
Alcoholism	☐	☐
Alzheimer's disease	☐	☐
Anemia	☐	☐
Cancer/Tumor	☐	☐
Diabetes type 1	☐	☐
Diabetes type 2	☐	☐
Diabetes unknown	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
Headache unlike any previously experienced	☐	☐
Heart condition	☐	☐
High cholesterol	☐	☐
Hypertension	☐	☐
Hypotension	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Parkinson's disease	☐	☐
Polio	☐	☐
Rheumatoid arthritis	☐	☐
Rheumatic fever	☐	☐
TIA's	☐	☐
Thyroid condition	☐	☐
Varicella Zoster (Shingles) virus	☐	☐

Family History

Relation	Age (now or at death)	Alive / Deceased	No significant disease	Arthritids	Blood disorders	Cancer	Diabetes (and type)	Epilepsy	Genetic disorders	Heart disease	Mental disease
Paternal grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s)			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s)			☐	☐	☐	☐	☐	☐	☐	☐	☐
Son(s)			☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter(s)			☐	☐	☐	☐	☐	☐	☐	☐	☐

All the answers I have given are correct to the best of my knowledge. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian/Spouse's signature authorizing care _____