

Pulse: DX: 1  
 Motor: 2  
 Reflex: 3  
 Height 4  
 Weight 5  
 Finger Nose: 6  
 Finger Taps

TX: **TODAY'S BILLING CODES**

INS CO

Sphinx:  
 VAS:  
 Hibbs:  
 Yeomans:  
 Rhomberg

**FUTURE CODES:**

**Byers Chiropractic Center**

139 N. State Route 42 Waynesville, OH 45068  
 Phone: (513) 897 - 0997 Fax: (513) 897 - 1678

**Case History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

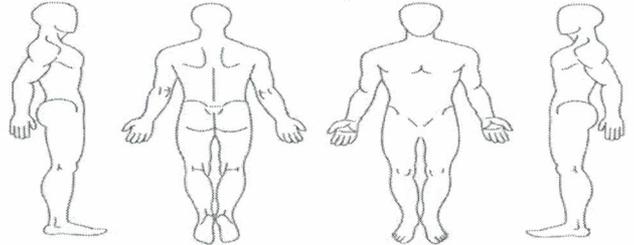
1. Circle the Severity (0 = No Pain to 10 = Very Severe Pain) & Frequency of pain (% of the week you experience the pain)

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain)

2. Symptoms are worse in the (circle what applies)

- Morning                      - Increase during the day
- Afternoon                   - Same all day
- Night                         - Decrease during the day



3. Symptom (a.) is:                      Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is:                      Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptom begin (onset date)? \_\_\_\_\_

6. How did your symptoms begin? \_\_\_\_\_

7. Have you experienced these before? \_\_\_\_\_

8. Do your symptoms radiate? \_\_\_\_\_

9. Has your condition? \_\_\_\_\_ Improved      \_\_\_\_\_ Gotten Worse      \_\_\_\_\_ Stayed the same since it began

10. Circle the thing that make your problems worse:

Bending / Lying / Walking / Standing / Sitting / Movement / Twisting / Lifting / Sleeping / Driving

11. Is there anything you can do to relieve the problems? \_\_\_ No \_\_\_ Yes, Describe: \_\_\_\_\_

If No, what have you tried that has not helped? \_\_\_\_\_

12. Have you been treated for this before? \_\_\_ No \_\_\_ Yes    How long ago? \_\_\_\_\_

13. What treatment did you receive? \_\_\_\_\_

14. Results of previous treatment? \_\_\_ Good \_\_\_ Poor    Comments: \_\_\_\_\_

15. Were you referred to our office by anyone? \_\_\_\_\_

16. Is this condition interfering with \_\_\_ Work \_\_\_ Sleep \_\_\_ Daily Routine \_\_\_ Recreation

17. List any other major injuries you have had, other than those mentioned above: \_\_\_\_\_

18. Any other musculoskeletal problems? \_\_\_ No \_\_\_ Yes                      Neurological Problems? \_\_\_ No \_\_\_ Yes

\*\*Additional Information on back of sheet \_\_\_\_\_

I certify that the above information is accurate to the best of my knowledge.

Patient / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_