Robert Casteel, D.C.
2733 Manitowoc Rd Ste 10
Green Bay, WI 54311

First Name: ________________ Last Name: ______________________

Address: ____________________ City: __________________ State: ______ Zip: ______

Birthday: ____/____/____ Gender: Male Female Marital Status S / M / W / D

Phone Number: __________________ Alternate Phone Number: __________________

Employer: __________________ Occupation: ________________ Years at this job: ____

Name of spouse: _________________ Children's name(s): _________________________

Email: ______________________

Referred by: ◯ Person________________ ◯ Doctor:_____________ ◯ Google ◯ Other

I hereby authorize Casteel Family Chiropractic to release my records as needed for timely payment of my care. I also authorize third party payment directly to Casteel Family Chiropractic. I understand that I am personally responsible to pay for all services rendered regardless of any insurance coverage or determination. This includes services not covered by my policy as well as if I have no insurance policy. I verify that I am 18 years or older or this form is signed by my parent or legal guardian.

Name (printed): ________________________________

Signature : ____________________________________ Date: ________________

How may we help?

What is your primary health concern? _______________________________________

Symptom Frequency: Constant **OR** _____ times per day/week/month (circle one)

Duration of Symptoms: All the time **OR** _____ seconds/minutes/hours (circle one)

Is your pain: Dull Sharp Throbbing Aching Shooting Other __________________

When did it start? ____

How did it start? ____

What makes it worse?______________ Better? ___________________

Rate your pain (0 = no pain, 10= you feel like you may pass out due to pain)

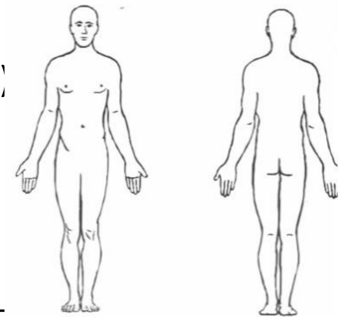
(circle) 0 1 2 3 4 5 6 7 8 9 10

I feel **Better** in the: AM PM I Feel **Worse**: AM PM

Have you had this before? Yes No When? ____________________

Other care/treatment for this condition? ___________________________

Mark symptom area with X's



Goals for your care? ◯ Pain relief ◯ Restore function ◯ Healthier spine ◯ Overall wellness

Other comments:____

____

Symptom 2 ____

Frequency: _______________ Duration: _____________________

Is your pain: Dull Sharp Throbbing Aching Shooting Other _________________

When did it start? __________________ How did it start? ______________________

What makes it worse?_____________ Better? __________________

Rate your pain (0 = no pain, 10= you feel like you may pass out due to pain)

(circle) 0 1 2 3 4 5 6 7 8 9 10

I feel **Better** in the: AM PM Feel **Worse**: AM PM

Have you had this before? Yes No When? ___________________

Symptom 3 ____

Frequency: _______________ Duration: _____________________

Is your pain: Dull Sharp Throbbing Aching Shooting Other _________________

When did it start? __________________ How did it start? ______________________

What makes it worse?_____________ Better? __________________

Rate your pain (0 = no pain, 10= you feel like you may pass out due to pain)

(circle) 0 1 2 3 4 5 6 7 8 9 10

I feel **Better** in the: AM PM Feel **Worse**: AM PM

Have you had this before? Yes No When? ___________________

Personal Medical History

Medications	Allergies	Spinal Injuries/Surgeries	Other Injuries/Surgeries
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

Are you under the care of any other health care provider/Doctor? ◯ Yes ◯ NO

If Yes, for what conditions? ____

Name of your Medical doctor: ___________________ Location: _________________

Review of Body Systems are you feeling: please circle

- Feverish, excessively fatigued or had a recent unexpected loss of weight? YES NO
- Persistent nausea, diarrhea, constipation, chronic abdominal pain or abnormal stool? YES NO
- Blurred/double vision, eye pain/discharge, failing vision, or light sensitivity? YES NO
- Ear pain/discharge, difficulty hearing/swallowing, frequent nose bleeds/sore throat? YES NO
- Chest pain, fainting spells, irregular heartbeat, shortness of breath, swollen ankles? YES NO
- Chronic cough or wheezing, coughing up blood, excessive phlegm? YES NO
- Painful/bloody/frequent/uncontrolled urination, unusual genital sores or discharge, Breast mass or tenderness, excessive menstrual flow or pain? YES NO
- Weakness, numbness, tingling, seizures, tremors/shaking or dizziness? YES NO
- Skin rash/itching/dryness, suspicious moles/patches or markings? YES NO

Additional comments: ____

____

Lifestyle/Wellness Information:

Diet/Nutrition:

Are you on any special diet? ◯ YES ◯ NO   If yes, what diet and why? ___________________________
____
How would you rate your eating habits? (10 = Great, 0 = Very Poor) 0 1 2 3 4 5 6 7 8 9 10
Vitamins/Supplements/Herbs

_______________________________   How many 8 oz. glasses of water do you drink per day? _____
_______________________________   How many caffeinated beverages do you drink per day? _____
_______________________________   How many alcoholic beverages?___/day ___/week ___/month
_______________________________   Do you use tobacco ◯ Yes ◯ No What kind?______________

Occupation/Daily Activities/Exercise:

Briefly describe your daily **work** activities including time spent sitting and standing, computer use, description of physical labor and repetitive motions: ____
____
Briefly describe your daily activities at **home** on most days of the week: __________________________
____
I exercise ____ days/week   Description of typical exercise___________________________________
Other lifestyle/wellness comments: ____
____

It is the mission of Casteel Family Chiropractic to help people understand how lifestyle choices such as diet, exercise and stress management can be combined with specific chiropractic care to enhance overall health and well-being. Would you like to discuss your lifestyle choices and how these can be improved to reduce risk for illness and disease as well as optimizing overall health?

◯ YES ◯ NO ◯ Maybe later * please understand that your doctor will likely discuss lifestyle factors to some degree even if you select "No" as they will impact recovery from your current condition.

I __________________________________ hereby affirm that all information on this form is accurate and complete to the best of my knowledge. I have not intentionally falsified or misrepresented any of the information provided above, and if any of this information changes in the future I will inform Casteel Family Chiropractic. I am 18 years or older or the signature below is my parent's or legal guardian's.

Signature: __________________________________ Date: ____/____/____

Relationship if minor: _________________________

"You can't go back and change the beginning, but you can start where you are and change the ending."
— C. S. Lewis