CASE HISTORY

Name: _____ Age: _____ Date: _____ E-mail: _____

Home phone: _____ Cell phone: _____

Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W Number of children(s): _____
Occupation: _____ Employer: _____ Telephone (Work): _____Ext.#
Spouse's Name: _____Spouse's Telephone: _____
Emergency Contact Name: _____ Phone Number: _____
Referred to our office by: _____
Past Chiropractic Care:☐ Yes ☐ No When?_____ Results: _____
Social Security Number_____ Driver's License Number: _____ State: _____

Chief Complaint: 1. _____ Duration-(How Long): _____ Previous Episodes: _____
List Current 2. _____ Duration-(How Long): _____ Previous Episodes: _____
Problems 3. _____ Duration-(How Long): _____ Previous Episodes: _____

Are your present problems due to an injury? ☐ No ☐ Yes ☐ On Job ☐ Auto Accident ☐ Personal Injury ☐ Other: _____
Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Auto Carrier ☐ Other: _____
Are you now or have you ever been disabled? (Service or Work) ☐ No ☐ Yes When? _____
Have you retained an attorney? ☐ No ☐ Yes Name & Address: _____

Please mark the intensity of your pain today.

1 - NO PAIN
10 - MOST INTENSE EVER FELT

Example _____ Neck
1 2 3 ❹ 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10

Left
2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

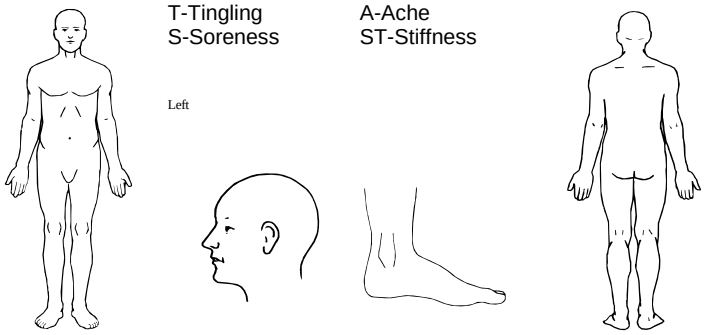
DOCTOR USE ONLY

_____
_____
_____
_____

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



HABITS

☐ Smoking Packs/Day: _____
☐ Drinking Alcohol: _____
☐ Coffee Cups/Day: _____
☐Water Glasses/Day: ___

EXERCISE

☐ None
☐ Moderate
☐ Daily
Type: _____
_____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, # of ____	☐	☐	☐	☐	☐
Sister, # of _____	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ 541	Appendicitis	☐ 280	Anemia	☐ 429.9	Heart Disease	☐ 716	Arthritis
☐ 480	Pneumonia	☐ 055	Measles	☐ 240	Goiter	☐ 345	Epilepsy
☐ 390	Rheumatic Fever	☐ 072	Mumps	☐ 487	Influenza	☐ 319	Mental Disorder
☐ 045	Polio	☐ 052	Chicken Pox	☐ 511	Pleurisy	☐ 724.2	Lumbago
☐ 011	Tuberculosis	☐ 250	Diabetes	☐ 305.0	Alcoholism	☐ 690	Eczema
☐ 033	Whooping Cough	☐ 239	Cancer	☐ 099	Venereal Disease	☐ 044	HIV Positive

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ☐ Never ☐ Previously ☐ Presently.

Never	Previously	Presently	GENERAL SYMPTOMS
☐	☐	☐	905.3 Allergy (What) _____
☐	☐	☐	491 Bronchitis
☐	☐	☐	780.9 Chills
☐	☐	☐	780.3 Convulsions
☐	☐	☐	780.4 Dizziness
☐	☐	☐	780.2 Fainting
☐	☐	☐	780.7 Fatigue
☐	☐	☐	780.6 Fever
☐	☐	☐	784.0 Headache
☐	☐	☐	780.52 Loss of Sleep
☐	☐	☐	783 Loss of weight
☐	☐	☐	799.2 Nervousness
☐	☐	☐	729.2 Neuralgia
☐	☐	☐	780.8 Night Sweats
☐	☐	☐	782 Numbness or pain in arms/legs/hands
☐	☐	☐	786.09 Wheezing

Never	Previously	Presently	GASTRO-INTESTINAL
☐	☐	☐	787.3 Belching or Gas
☐	☐	☐	789.0 Colon Trouble
☐	☐	☐	564.0 Constipation
☐	☐	☐	558.9 Diarrhea
☐	☐	☐	783.6 Excessive Hunger
☐	☐	☐	575.9 Gall Bladder Trouble
☐	☐	☐	455.6 Hemorrhoids (piles)
☐	☐	☐	782.4 Jaundice
☐	☐	☐	794.8 Liver Trouble
☐	☐	☐	787.0 Nausea
☐	☐	☐	536.8 Stomach Pain
☐	☐	☐	783.0 Poor Appetite
☐	☐	☐	536.8 Poor Digestion
☐	☐	☐	787.0 Vomiting
☐	☐	☐	578.0 Vomiting Blood

Never	Previously	Presently	EYE/EAR/NOSE/THROAT
☐	☐	☐	493.9 Asthma
☐	☐	☐	378.9 Crossed Eyes
☐	☐	☐	389.9 Deafness
☐	☐	☐	388.70 Earache
☐	☐	☐	388.60 Ear Discharge
☐	☐	☐	388.30 Ear Noises
☐	☐	☐	240.9 Enlarged Thyroid
☐	☐	☐	460 Frequent Colds
☐	☐	☐	477.9 Hay Fever
☐	☐	☐	784.49 Hoarseness
☐	☐	☐	478.1 Nasal Obstruction
☐	☐	☐	784.7 Nose Bleeds
☐	☐	☐	379.91 Pain in Eyes
☐	☐	☐	368.9 Poor Vision
☐	☐	☐	473.9 Sinusitis
☐	☐	☐	462 Sore Throats
☐	☐	☐	463 Tonsillitis

Never	Previously	Presently	RESPIRATORY
☐	☐	☐	786.50 Chest Pain
☐	☐	☐	786.2 Chronic Cough
☐	☐	☐	786.09 Difficulty Breathing
☐	☐	☐	786.3 Spitting Blood
☐	☐	☐	786.4 Spitting Phlegm

GENITO-URINARY

☐	☐	☐	788.3 Bed Wetting
☐	☐	☐	599.7 Blood in Urine
☐	☐	☐	788.4 Frequent Urination
☐	☐	☐	788.3 Inability to Control Urine
☐	☐	☐	590.9 Kidney Infection
☐	☐	☐	788.1 Painful Urination
☐	☐	☐	601.9 Prostate Trouble

			MUSCLES & JOINTS
☐	☐	☐	724.5 Backache
☐	☐	☐	719.7 Foot Trouble
☐	☐	☐	550.0 Hernia
☐	☐	☐	719.1 Pain Between Shoulders
☐	☐	☐	724.6 Painful Tail Bone
☐	☐	☐	723.9 Stiff Neck
☐	☐	☐	781.9 Spinal Curvature
☐	☐	☐	719.0 Swollen Joints
☐	☐	☐	781.0 Tremors
☐	☐	☐	781.0 Twitching

			CARDIO-VASCULAR
☐	☐	☐	401.9 High Blood Pressure
☐	☐	☐	458.9 Low Blood Pressure
☐	☐	☐	786.51 Pain over Heart
☐	☐	☐	785.9 Poor Circulation
☐	☐	☐	438 Previous Heart Trouble
☐	☐	☐	785.0 Rapid Heart
☐	☐	☐	427.89 Slow Heart
☐	☐	☐	436 Strokes
☐	☐	☐	782.3 Swelling Ankles
☐	☐	☐	454 Varicose Veins

			SKIN OR ALLERGIES
☐	☐	☐	690 Boils
☐	☐	☐	924.9 Bruising Easily
☐	☐	☐	701.1 Dryness
☐	☐	☐	691.8 Eczema
☐	☐	☐	708.9 Hives or Allergy
☐	☐	☐	698.9 Itching
☐	☐	☐	782.0 Sensitive Skin
☐	☐	☐	368.9 Skin Eruptions

FOR WOMEN ONLY

☐	☐	☐	625.3 Cramps or Backaches
☐	☐	☐	626.2 Excessive Flow
☐	☐	☐	627.2 Hot Flashes
☐	☐	☐	626.4 Irregular Cycle
☐	☐	☐	634.9 Miscarriage
☐	☐	☐	625.3 Painful Periods
☐	☐	☐	623.5 Vaginal Discharge
☐Yes	☐No		Pregnant at this time
_____			Last Pap Date
_____			by Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

☐ I have never had any operations / surgeries

List any accidents or falls and dates: ☐ Car: _____ ☐ Recreation Vehicle: _____
☐ Sports: _____ ☐ School: _____ ☐ Other: _____
List any broken bones (fractures) or dislocations: _____
Have you ever been on crutches? ☐ Yes ☐ No Why? _____
Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No
Have you ever had a lapse of memory? ☐ Yes ☐ No
Have you ever had X-rays taken? ☐ Yes ☐ No When? _____ By Whom? _____
For what ailments were these X-rays made? _____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication - prescription or over-the-counter? ☐ No ☐ Yes what drugs? _____
_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, 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.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X _____ Date: _____