CASE HISTORY

Name: ______ Age: ______ Date: ______ E-mail: ______
Address: ______ City: ______ State: ______ Zip: ______
Phone(Home): ______ Date of Birth: ______ Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W # Children: ______
Occupation: ______ Employer: ______ Telephone (Work): ______ Ext.# ______
Insured's Name: ______ Phone: ______ Insured's Date of Birth: ______
Spouse's Name: ______ Spouse's Occupation: ______
Spouse's Employer: ______ Spouse's Telephone (Work): ______
Referred by: ______ Past Chiropractic Care: ☐ Yes ☐ No When? ______
Doctor's Name: ______ Results: ______
Insurance Company: ______ Telephone: ______
Social Security Number: ______ Driver's License Number: ______ State: ______
Spouse's Insurance Company: ______ Telephone: ______
Spouse's Social Security Number: ______ Spouse's Driver's License Number: ______

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 4 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

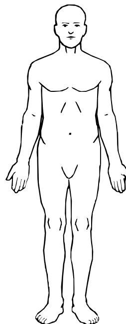
3. ______
1 2 3 4 5 6 7 8 9 10

DOCTOR USE ONLY

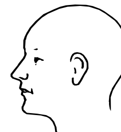
______
______
______
______

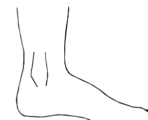
Please mark area & type of pain on the drawings using the codes listed below.

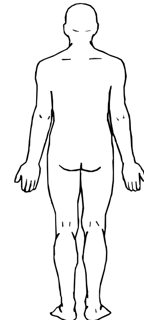
N-Numbness P-Pain
T-Tingling A-Ache
S-Soreness ST-Stiffness



Left







HABITS

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

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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	Code	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	Code	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	Pain over Stomach
☐	☐	☐	783.0	Poor Appetite
☐	☐	☐	536.8	Poor Digestion
☐	☐	☐	787.0	Vomiting
☐	☐	☐	578.0	Vomiting Blood

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

Never	Previously	Presently	Code	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

Never	Previously	Presently	Code	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

Never	Previously	Presently	Code	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

Never	Previously	Presently	Code	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

Never	Previously	Presently	Code	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: ____

Ever 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 myself. 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: ______________________

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