CASE HISTORY

Name:_____ Age:_____ Date of birth:_____ Today's date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____ Sex:☐M ☐F Marital status:☐S ☐M ☐O # Children:_____

Occupation:_____ Employer:_____ Work phone:_____ Ext.#_____

E-mail address (if okay to use):_____ Referred by:_____

Insured's name:_____ Phone:_____ Insured's date of birth:_____

Insured's employer:_____ Insured's occupation:_____

Primary physician:_____ Okay to coordinate care with/contact primary? ☐Yes ☐No

Past chiropractic care?: ☐Yes ☐No When?_____ Results:_____

Insurance company:_____ Identification #:_____

Social security #:_____ Driver's license #:_____ State:_____

Chief complaint: 1._____ Duration- (how long):_____ Previous episodes:_____

2._____ Duration- (how long):_____ Previous episodes:_____

list current problems 3._____ Duration- (how long):_____ Previous episodes:_____

4._____ 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

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

_____

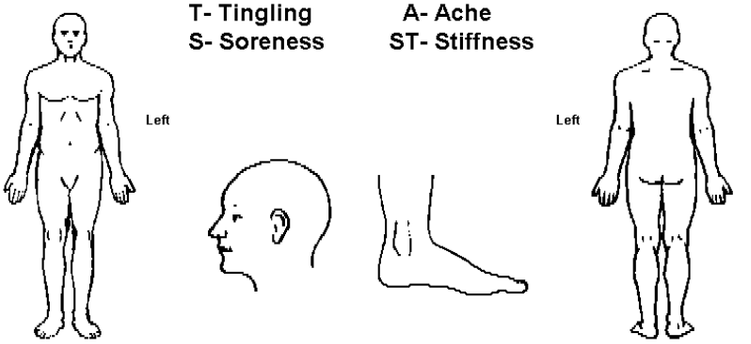
_____

_____

_____

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



HABITS

☐ Smoking Packs/Day:_____

☐ Drinking Alcohol:_____

☐ Coffee Cups/Day:_____

EXERCISE

☐ None

☐ Moderate

☐ Daily

Type:_____

_____

FAMILY HISTORY

	Heart	Kidney	Cancer	Back	Diabetes
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

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed.

Never	Previously	Presently	GENERAL SYMPTOMS	
☐	☐	☐	905.3	Allergy (to 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	Pain over Stomach
☐	☐	☐	783.0	Poor Appetite
☐	☐	☐	536.8	Poor Digestion
☐	☐	☐	787.0	Vomiting
☐	☐	☐	578.0	Vomiting Blood
☐	☐	☐	787.2	Diff Swallowing

Never	Previously	Presently	EYE/EAR/NOSE/THROAT	
☐	☐	☐	493.9	Asthma
☐	☐	☐	378.9	Crossed Eyes
☐	☐	☐	389.9	Deafness
☐	☐	☐	388.7	Earache
☐	☐	☐	388.6	Ear discharge
☐	☐	☐	388.3	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	Tonsilitis

Never	Previously	Presently	RESPIRATORY	
☐	☐	☐	786.5	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

Never	Previously	Presently	MUSCLES & JOINTS	
☐	☐	☐	724.5	Backache
☐	☐	☐	719.7	Foot Trouble
☐	☐	☐	550.0	Hernia
☐	☐	☐	719.1	Pain Between Shoulders
☐	☐	☐	724.6	Painful Tailbone
☐	☐	☐	723.9	Stiff Neck
☐	☐	☐	781.9	Spinal Curvature
☐	☐	☐	719.0	Swollen Joints
☐	☐	☐	781.0	Tremors
☐	☐	☐	781.0	Twitching

Never	Previously	Presently	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	SKIN OR ALLERGIES	
☐	☐	☐	690	Boils
☐	☐	☐	924.9	Bruising Easily
☐	☐	☐	701.1	Dryness
☐	☐	☐	691.8	Eczema
☐	☐	☐	708.9	Hives or Allergies
☐	☐	☐	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 currently

_____ 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 Surgery	_____	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 have any other health factors / conditions other than that for which you are consulting us? _____

Are you presently taking any medication, prescription or over-the-counter? ☐ Yes ☐ No What? _____

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/she 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: _____