CASE HISTORY

Name _____ Age _____ Date _____ Case Number _____

Address _____ City _____ State _____ Zip _____

Phone(Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W #Children _____

Occupation _____ Employer _____ Telephone (Work) _____

Referred by _____ Past Chiropractic Care ❑Yes ❑ No When _____

Doctor's Name _____ Results _____

For those with insurance, please answer the following questions:

Insured's Name _____ Insured's Date of Birth _____

Spouse's Name _____ Insurance account # _____

Spouse's Employer _____

Insurance Company _____ Telephone _____

Fill out for Medicare cases:

Social Security# _____

Chief Complaint / List Current Problems

1. _____ Duration-(How Long) _____ Previous Episodes ____
2. _____ Duration-(How Long) _____ Previous Episodes ____
3. _____ Duration-(How Long) _____ Previous Episodes ____

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the 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

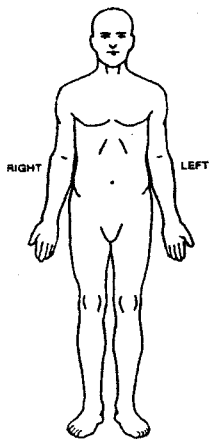
3. _____
1 2 3 4 5 6 7 8 9 10

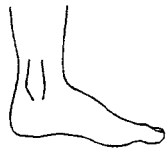
DOCTORS USE ONLY

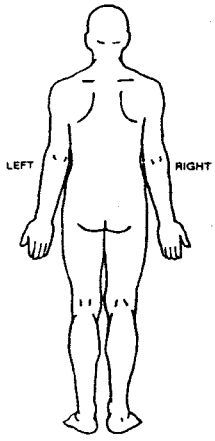
_____
_____
_____
_____
_____

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

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







HABITS

❑ Smoking Packs/Day _____
❑ Drinking Alcohol _____
❑ Coffee Cups/Day _____

EXERCISE

❑ None
❑ Moderate
❑ Daily
Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother, No. of ____	❑	❑	❑	❑	❑
Sister, No. 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 Infection
❑ 716 Arthritis
❑ 345 Epilepsy
❑ 319 Mental Disorder
❑ 724.2 Lumbago
❑ 690 Eczema
❑ 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

Never	Previously	Presently		
☐	☐	☐	995.3	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

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
☐	☐	☐	728.8	Weakness

GASTRO-INTESTINAL

Never	Previously	Presently		
☐	☐	☐	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

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

EYE/EAR/NOSE/THROAT

Never	Previously	Presently		
☐	☐	☐	493.9	Asthma
☐	☐	☐	378.9	Crossed Eyes
☐	☐	☐	389.9	Deafness
☐	☐	☐	388.70	Earache
☐	☐	☐	388.60	Ear Discharges
☐	☐	☐	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

SKIN OR ALLERGIES

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

RESPIRATORY

Never	Previously	Presently		
☐	☐	☐	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

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

☐ 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_____ ☐ Recreational Vehicle _____
☐ Sports_____ ☐ School _____ ☐ Other _____

List any broken bones (fractures) or dislocations : _____

Ever on crutches? ☐ No ☐ Yes 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? ☐ No ☐ Yes 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_____