



CASE HISTORY

Name: _____ Age: _____ Date: _____ Height: _____ Weight: _____

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

What would you like to be called? _____ Marital Status: Single Married Divorced Widow(er)

Social Security Number: _____ Date of Birth: _____

Phone (Home): _____ Email Address: _____

Telephone (Work): _____ Ext.# _____ Cell Phone #: _____

Sex: Male Female # of Children: _____ Occupation: _____ Employer: _____ 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? _____

Insurance Company: _____ Telephone: _____

Driver's License Number: _____ State: _____

Spouse's Insurance Company: _____ Telephone: _____

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

1. LOW BACK PAIN
1 2 3 4 5 6 7 8 9 10

2. ALL OTHER PAIN
1 2 3 4 5 6 7 8 9 10

HABITS

- Smoking Packs/Day _____
- Drinking Alcohol: _____
- Coffee Cups/Day: _____
- Cola (caffeine) Cans/Day: _____

EXERCISE

- None
- Moderate
- Daily
- Type: _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> 541 Appendicitis | <input type="checkbox"/> 280 Anemia | <input type="checkbox"/> 429.9 Heart Disease | <input type="checkbox"/> 716 Arthritis |
| <input type="checkbox"/> 480 Pneumonia | <input type="checkbox"/> 055 Measles | <input type="checkbox"/> 240 Goiter | <input type="checkbox"/> 345 Epilepsy |
| <input type="checkbox"/> 390 Rheumatic Fever | <input type="checkbox"/> 072 Mumps | <input type="checkbox"/> 487 Influenza | <input type="checkbox"/> 319 Mental Disorder |
| <input type="checkbox"/> 045 Polio | <input type="checkbox"/> 052 Chicken Pox | <input type="checkbox"/> 511 Pleurisy | <input type="checkbox"/> 724.2 Lumbago |
| <input type="checkbox"/> 011 Tuberculosis | <input type="checkbox"/> 250 Diabetes | <input type="checkbox"/> 305.0 Alcoholism | <input type="checkbox"/> 690 Eczema |
| <input type="checkbox"/> 033 Whooping Cough | <input type="checkbox"/> 239 Cancer | <input type="checkbox"/> 099 Venereal Disease | <input type="checkbox"/> 044 HIV Positive |
| <input type="checkbox"/> 905.3 Allergy(What) | <input type="checkbox"/> 787.3 Belching or Gas | <input type="checkbox"/> 493.9 Asthma | <input type="checkbox"/> 786.50 Chest Pain |

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

<input type="checkbox"/> 491	Bronchitis	<input type="checkbox"/> 789.0	Colon Trouble	<input type="checkbox"/> 378.9	Crossed Eyes	<input type="checkbox"/> 786.2	Chronic Cough
<input type="checkbox"/> 780.9	Chills	<input type="checkbox"/> 564.0	Constipation	<input type="checkbox"/> 389.9	Deafness	<input type="checkbox"/> 786.09	Difficulty Breathing
<input type="checkbox"/> 780.3	Convulsions	<input type="checkbox"/> 558.9	Diarrhea	<input type="checkbox"/> 388.70	Earache	<input type="checkbox"/> 786.3	Spitting Blood
<input type="checkbox"/> 780.4	Dizziness	<input type="checkbox"/> 783.6	Excessive Hunger	<input type="checkbox"/> 388.60	Ear Discharge	<input type="checkbox"/> 786.4	Spitting Phlegm
<input type="checkbox"/> 780.7	Fatigue	<input type="checkbox"/> 575.9	Gall Bladder Trouble	<input type="checkbox"/> 388.30	Ear Noises		
<input type="checkbox"/> 780.6	Fever	<input type="checkbox"/> 782.4	Jaundice	<input type="checkbox"/> 460	Frequent Colds	<input type="checkbox"/> 788.3	Bed Wetting
<input type="checkbox"/> 784.0	Headache	<input type="checkbox"/> 794.8	Liver Trouble	<input type="checkbox"/> 477.9	Hay Fever	<input type="checkbox"/> 599.7	Blood in Urine
<input type="checkbox"/> 780.52	Loss of Sleep	<input type="checkbox"/> 787.0	Nausea	<input type="checkbox"/> 784.49	Hoarseness	<input type="checkbox"/> 788.4	Frequent Urination
<input type="checkbox"/> 783	Loss of weight	<input type="checkbox"/> 536.8	Pain over Stomach	<input type="checkbox"/> 478.1	Nasal Obstruction	<input type="checkbox"/> 788.3	Inability to Control Urine
		<input type="checkbox"/> 783.0	Poor Appetite	<input type="checkbox"/> 784.7	Nose Bleeds		

MUSCLES & JOINTS		CARDIO-VASCULAR		SKIN OR ALLERGIES		FOR WOMEN ONLY	
<input type="checkbox"/> 724.8	Backache	<input type="checkbox"/> 401.9	High Blood Pressure	<input type="checkbox"/> 690	Boils	<input type="checkbox"/> 625.3	Cramps or Backaches
<input type="checkbox"/> 719.7	Foot Trouble	<input type="checkbox"/> 458.9	Low Blood Pressure	<input type="checkbox"/> 924.9	Bruising Easily		Excessive Flow
<input type="checkbox"/> 550.0	Hernia	<input type="checkbox"/> 786.51	Pain over Heart	<input type="checkbox"/> 701.1	Dryness	<input type="checkbox"/> 626.2	Hot Flashes
<input type="checkbox"/> 719.1	Pain Between Shoulders	<input type="checkbox"/> 785.9	Poor Circulation	<input type="checkbox"/> 691.8	Eczema	<input type="checkbox"/> 627.2	Irregular Cycle
<input type="checkbox"/> 724.6	Painful Tail Bone	<input type="checkbox"/> 438	Previous Heart Trouble	<input type="checkbox"/> 708.9	Hives or Allergy	<input type="checkbox"/> 626.4	Miscarriage
<input type="checkbox"/> 723.9	Stiff Neck	<input type="checkbox"/> 785.0	Rapid Heart	<input type="checkbox"/> 698.9	Itching	<input type="checkbox"/> 634.9	Painful Periods
<input type="checkbox"/> 781.9	Spinal Curvature	<input type="checkbox"/> 427.89	Slow Heart	<input type="checkbox"/> 782.0	Sensitive Skin	<input type="checkbox"/> 625.3	Vaginal Discharge
<input type="checkbox"/> 719.0	Swollen Joints	<input type="checkbox"/> 436	Strokes	<input type="checkbox"/> 368.9	Skin Eruptions	<input type="checkbox"/> 623.5	Pregnant at this time
<input type="checkbox"/> 781.0	Tremors	<input type="checkbox"/> 782.3	Swelling Ankles	FOR MEN ONLY		<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Pap Date
<input type="checkbox"/> 781.0	Twitching	<input type="checkbox"/> 454	Varicose Veins	<input type="checkbox"/>	Frequent urination		By Whom
				<input type="checkbox"/>	Prostate problems		
				<input type="checkbox"/>	Erection problems		

DATES OF OPERATIONS AND PROCEDURES

_____ 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 - prescribed 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: _____