# CASE HISTORY

Name _____ 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) _____

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 # _____ Driver's License # _____

Spouse's Insurance Co. _____ Telephone _____

Spouse's Social Security # _____ Spouse's Driver's License # _____

Chief Complaint 1. _____

(List Current Problems) 2. _____

3. _____

EMAIL ADDRESS → _____

Are your present problems due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto Accident ☐ Personal Injury ☐ Other

Have you made a report of your accident? ☐ No ☐ Yes ☐ To employer ☐ Auto Carrier ☐ Other _____

Has the accident been reported? ☐ No ☐ Yes ☐ Workers' Comp. ☐ 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 GIVE MOST CURRENT DATE

Spinal Exam _____

Disc. Exam _____

X-ray Exam _____

Lab Exam _____

Last Physical _____

FEMALE ONLY

Pap smear _____

Breast exam _____

**DOCTORS USE ONLY**

_____

_____

_____

_____

_____

**SEVERITY OF PAIN**

List region of pain and circle severity number [1 = least, 10 = greatest]

ex. Neck 1 2 3 4 5 6 7 8 9 10

MARK PAIN AREA

+++ Burning

000 Stabbing

--- Sharp

||| Constant

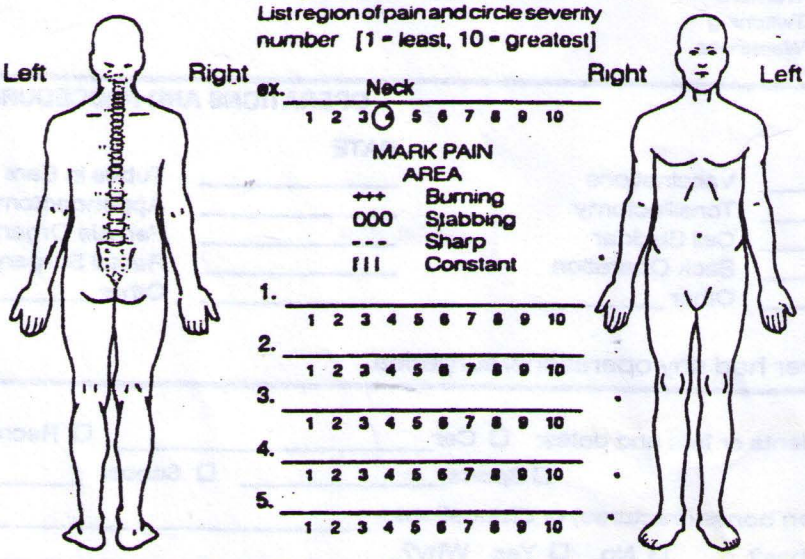
1. _____ 1 2 3 4 5 6 7 8 9 10

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

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

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

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




Please mark area of pain on the drawing using the code listed above.

**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 | ☐ 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 | | |
| ☐ | 011 Tuberculosis | ☐ 250 | Diabetes | ☐ | 305.0 Alcoholism | ☐ 724.2 | Lumbago |
| ☐ | 033 Whooping Cough | ☐ 239 | Cancer | ☐ | 099 Venereal | ☐ 690 | Eczema |

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 |

## 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 |

## 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 |

## 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

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 |

## CARDIO-VASCULAR

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 |

## FOR WOMEN ONLY

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 necessa 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. Howev 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 treatme 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 understo 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 t 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 diagno

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