

**CASE HISTORY**

Account # \_\_\_\_\_

Legal Name \_\_\_\_\_ Date \_\_\_\_\_ Marital Status M S D W  
 Name you would prefer to be called \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_ Sex M  F   
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Referred by \_\_\_\_\_  
 Your social security number \_\_\_\_\_ Spouse SS# \_\_\_\_\_  
 Have you seen a chiropractor before? Yes  No  Chiropractor's name \_\_\_\_\_  
 Who is your primary care physician? \_\_\_\_\_  
 Reason for your visit today 1. \_\_\_\_\_  
 (Please list areas of pain) 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 Date of accident or beginning of symptoms \_\_\_\_\_

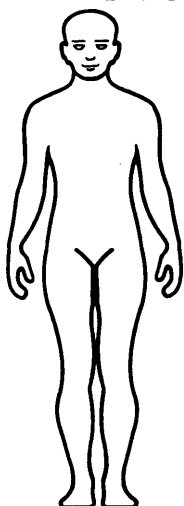
**INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Spouse's insurance company \_\_\_\_\_ Phone \_\_\_\_\_  
 Are present symptoms due to an injury? Yes  No  On the job  Auto Accident  Personal Injury   
 Has the accident been reported? Yes  No  To Worker's Comp?  To Auto Carrier?   
 Have you retained an attorney? Yes  No  Name and phone number \_\_\_\_\_

**SEVERITY OF PAIN**

List the area of pain and circle the number below to describe the amount of pain with "1" indicating minor discomfort and "10" representing severe pain.

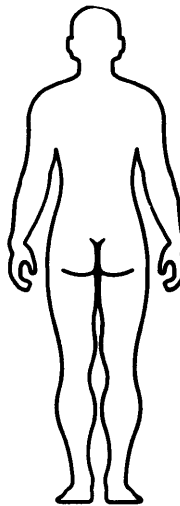
Example: Lower back  
 1 2 3 4 5 6 7 8 9 10



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
4. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10
5. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

**MARK PAIN**

- +++ Burning
- 000 Stabbing
- Sharp
- /// Aching



Please mark areas of pain on the drawings using the code above.

Please list any concerns about your symptoms and anything else you would like the doctor to know:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE TURN PAGE OVER AND COMPLETE REVERSE SIDE.  
 THANK YOU.

**HABITS**

Smoking Packs per day \_\_\_\_\_  
 Alcohol Drinks per day \_\_\_\_\_  
 Coffee/Tea Cups per day \_\_\_\_\_  
 Vitamins/herbs (list all being taken) \_\_\_\_\_

**EXERCISE**

- None
- Moderate
- Daily

**FAMILY HISTORY**

Has any member of your family had any of the following diseases?

- Diabetes  Heart
- Kidney  Cancer
- Arthritis  Lung

Have you had any of the following?

- Appendicitis
- Heart Disease
- Pneumonia
- Polio
- Diabetes
- Rheumatic Fever
- Anemia
- Arthritis
- Epilepsy
- Tuberculosis
- Hypertension
- Aids
- Cancer
- Tuberculosis
- Alcoholism

**GENERAL SYMPTOMS**

- Headaches
- Fever
- Night Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Loss of Weight
- Allergies
- Weakness
- Twitching

**GASTRO-INTESTINAL**

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Stomach Pain
- Constipation
- Diarrhea
- Hemorrhoids
- Liver Trouble
- Jaundice
- Gall Bladder

**EENT**

- Poor Vision
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Nosebleeds
- Sore Throat
- Hoarseness
- Hay Fever
- Asthma
- Frequent Colds
- Thyroid Trouble
- Tonsillitis
- Sinus Trouble

**RESPIRATORY**

- Cough
- Short of Breath

**GENITO-URINARY**

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infections
- Bed Wetting
- Incontinence
- Prostate Trouble
- Bladder Infections

**MUSCLE AND JOINTS**

- Stiff Neck
- Neck Pain
- Middle Back Pain
- Lower Back Pain
- Arm Pain
- Arm Numbness
- Leg Pain
- Leg Numbness
- Swollen Joints
- Painful Tailbone
- Foot Pain
- Spinal Curvature

**CARDIOVASCULAR**

- Rapid Heartbeat
- Slow Heartbeat
- High Blood Pressure
- Chest Pain
- Swelling Ankles
- Poor Circulation
- Varicose Veins
- Stroke
- Heart Attack

**SKIN**

- Itching
- Bruise Easily
- Dry Skin
- Boils
- Sensitive Skin
- Hives
- Eczema

**FOR WOMEN ONLY**

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Hot Flashes
- Cramps
- Vaginal Discharge
- Currently Pregnant
- Breast Implants
- Date of last PAP  
\_\_\_\_\_

PLEASE CHECK OFF ALL SYMPTOMS THAT CURRENTLY APPLY TO YOU.

**HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES? IF YES, PLEASE LIST THE DATE.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hip _____           | <input type="checkbox"/> Gall Bladder _____  | <input type="checkbox"/> Hernia _____            |
| <input type="checkbox"/> Tubes in Ears _____ | <input type="checkbox"/> Stomach _____       | <input type="checkbox"/> Hip/Knee _____          |
| <input type="checkbox"/> Sinus _____         | <input type="checkbox"/> Appendectomy _____  | <input type="checkbox"/> Vision Correction _____ |
| <input type="checkbox"/> Thyroid _____       | <input type="checkbox"/> Female Organs _____ | <input type="checkbox"/> Breast _____            |
| <input type="checkbox"/> TMJ _____           | <input type="checkbox"/> Hemorrhoids _____   | <input type="checkbox"/> Mastectomy _____        |
| <input type="checkbox"/> Neck _____          | <input type="checkbox"/> Back _____          | <input type="checkbox"/> Prostate _____          |

**LIST ANY ACCIDENTS, INJURIES, FALLS AND THE DATE.**

- Car \_\_\_\_\_
  - Sports \_\_\_\_\_
  - School \_\_\_\_\_
  - Other \_\_\_\_\_
- List any broken bones or dislocations: \_\_\_\_\_
- Have you ever had a spinal tap or injection?  Yes  No
- Have you ever been knocked unconscious?  Yes  No
- Have you ever had a lapse of memory?  Yes  No

Have you ever had x-rays, MRI or CT Scan of your spine?  Yes  No When? \_\_\_\_\_

Do you suffer from any condition other than that for which you are consulting us? \_\_\_\_\_

Are you presently taking any prescription medication?  Yes  No If yes, please list: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_