

# CASE HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Case Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone:(H) \_\_\_\_\_ (C) \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  D  W # of Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Telephone (Work): \_\_\_\_\_ Ext. \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Telephone (Work): \_\_\_\_\_  
 Past Chiropractic Care:  Yes  No When? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_  
 Results: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_  
 Spouse's Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Spouse's Social Security Number: \_\_\_\_\_ Spouse's Driver's License Number: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Contact Number \_\_\_\_\_

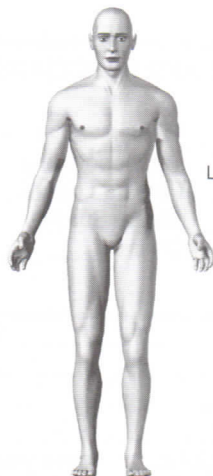
Are your present problems due to an injury?  No  Yes  On the Job  Auto Accident  Personal Injury  Other: \_\_\_\_\_  
 Has the accident been reported?  No  Yes  To Employer  Auto Carrier  Other: \_\_\_\_\_  
 Are you now or have you ever been disabled? (Service or Work)?  No  Yes When? \_\_\_\_\_ Why? \_\_\_\_\_  
 Have you retained an attorney?  No  Yes Name & Address: \_\_\_\_\_

Pain Symptoms: 1. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 (in order of severity) 2. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 3. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_

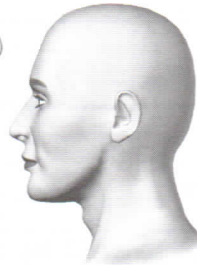
**Please mark the intensity of your pain today.**  
 0 - NO PAIN  
 10 - INTENSE PAIN  
 Example Neck  
 O 1 2 3 ④ 5 6 7 8 9 10  
 1. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10  
 2. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10  
 3. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10


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

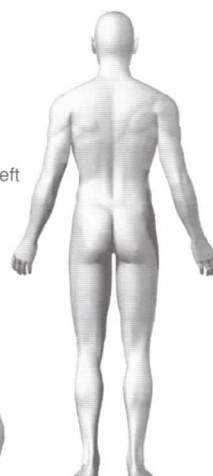
	N-Numbness T-Tingling S-Soreness	P-Pain A-Ache ST-Stiffness
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Left







Left

**DOCTORS USE ONLY**

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**HABITS**

Smoking Packs/Day: \_\_\_\_\_  
 Drinking Alcohol: \_\_\_\_\_  
 Caffeine Cups/Day: \_\_\_\_\_

**EXERCISE**

None  
 Light Activity  
 Moderate Activity  
 Active  
 Very Active  
 Elite Athlete

**FAMILY HISTORY**

	Diabetes	Heart	Kidney	Cancer	Other
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, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?**

<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"/> 303.9 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"/> 042 HIV Positive
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 346.9 Migraine Headaches	<input type="checkbox"/> 054.9 Herpes	<input type="checkbox"/> 340 Multiple Sclerosis

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

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td><b>GENERAL SYMPTOMS</b></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>995.3 Allergy (What)_____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>490 Bronchitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.9 Chills</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.39 Convulsions</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.4 Dizziness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.2 Fainting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.79 Fatigue</td> </tr> <tr> <td><input 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**OPERATIONS AND PROCEDURES**

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I have never had any operations / surgeries

List any accidents or falls and dates:  Car: \_\_\_\_\_  Recreation: \_\_\_\_\_  
 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 - prescription or over-the-counter?  Yes  No What drugs? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Name : \_\_\_\_\_

Date : \_\_\_\_\_

Do you have any close family history (father/mother, grandparents, aunts/uncles) of any of the following:

- Thyroid problems    Diabetes    Gout    Heart conditions    Kidney problems    Ovarian/uterine problems  
 Liver problems    Gallbladder problems    Stomach problems    Colon problems    Lung conditions    Strokes

Have you had the flu, a cold, or a respiratory illness (cough) in the last 3 weeks?    Yes    No

Do you smoke?    Yes    No   When was your last smoke?: \_\_\_\_\_

Have you experienced a recent trauma (a fall, sports injury, car accident, dental work, surgery, etc.)?    Yes    No

**Please answer the following questions in regard to the chief complaints you described on page #1.**

**COMPLAINT**

1: \_\_\_\_\_

2: \_\_\_\_\_

3: \_\_\_\_\_

When and how did this problem begin ?

- suddenly    gradually

\_\_\_\_\_  
\_\_\_\_\_

- suddenly    gradually

\_\_\_\_\_  
\_\_\_\_\_

- suddenly    gradually

\_\_\_\_\_  
\_\_\_\_\_

What makes it better ? / What makes it worse ?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How would you describe your pain/symptoms ?

- achy    sharp    burning  
 sore    tight & stiff  
 numb    pins & needles

- achy    sharp    burning  
 sore    tight & stiff  
 numb    pins & needles

- achy    sharp    burning  
 sore    tight & stiff  
 numb    pins & needles

How often do you experience your pain/symptoms ?

- constantly (100%)    frequently (75%)  
 intermittently (50%)    occasionally (25%)

- constantly    frequently  
 intermittently    occasionally

- constantly    frequently  
 intermittently    occasionally

Does the pain radiate anywhere ?

- down the arms    legs

\_\_\_\_\_

- down the arms    legs

\_\_\_\_\_

- down the arms    legs

\_\_\_\_\_

Is your complaint affected by the time of day ?

- worse in the morning    evening  
 better in the morning    evening

- worse in morning    evening  
 better in morning    evening

- worse in morning    evening  
 better in morning    evening

Are you getting: (Circle) worse / better / same

worse / better / same

worse / better / same