

CASE HISTORY

Name _____ Age _____ Date _____ Email _____
 Address _____ City _____ State _____ Zip _____
 Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W P
 Social Security # _____ Occupation/Employer _____ Phone (Work) _____
Whom can we thank for referring you? _____
 Emergency Contact _____ Relation _____ Phone# _____
 Insurance Company _____
 Insured' s Name _____ Insured' s Date of Birth _____
 Spouse' s Name _____ Spouse' s Occupation _____ Spouse' s Phone (Work) _____
 Present condition due to an injury? Yes No On the J ob Auto Accident Other _____
 Has the accident been reported? Yes No To Employer Auto Carrier Other _____

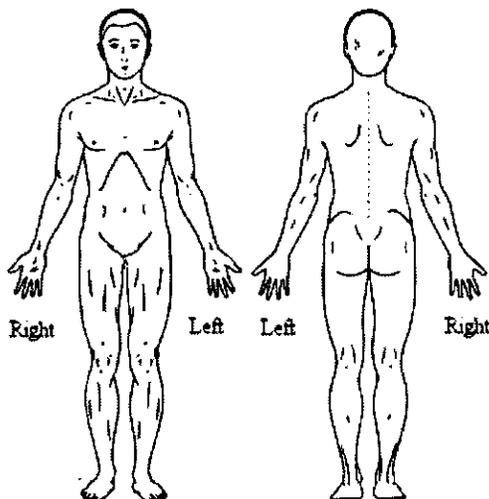
HEALTH REPORT:

Reason for seeking care: _____
 Have you seen any other Doctors for this condition? Yes No If yes, who _____
 Have you had similar accidents or injuries before? Yes No If yes, explain: _____
 Have you received chiropractic treatment previously? Yes No If yes, explain: _____
 Have you been treated for any health condition by a physician in the last year? Yes No
 If yes, explain: _____
 Are you currently taking medication? Yes No list medications: _____

 List the conditions you are taking medications for: _____
 List the approximate dates of any surgery or treated conditions: _____

Family History: Health conditions, age of death and cause of death.

Father: _____
 Mother: _____
 Brother/s & Sister/s: _____
 Do you smoke Y/N _____ • Alcohol Y/N Daily Weekly Social Occasions • Caffeinated drinks per day _____
 Do you take Vitamins/Supplements Y/N If yes, type and how often _____
 Hobbies/Recreational Activities: _____



Please circle degree of pain, 0 none, 10 severe pain.
 0 1 2 3 4 5 6 7 8 9 10
 Using the symbols below, mark on the pictures where you feel pain.
 Numbness * * *
 Dull/Ache O O O
 Burning X X X
 Sharp/Stabbing / / /
 Pins/Needles + + +
 Other _____ ^ ^ ^

What % of time when awake do you feel this pain? 0%-100% _____
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is this condition worse during certain times of the day? Y/N If yes circle one:
 Morning Afternoon Evening Night Unaffected by time of day

Is this condition interfering with Work? _____ Sleep? _____ Routine? _____ Other? _____
 Is this condition progressively getting worse? Y/N
 Does your condition radiate/travel to other parts of your body? Y/N If yes, where? _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises

- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergies

FOR WOMEN ONLY

- Birth Control
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

Pregnancies _____

Date/Dates of delivery: _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. Our policy requires payment in full of all services rendered at the time of visit, unless other arrangements have been made with the doctor. I agree to allow this office to examine me further for evaluation, diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Patient

Signature _____ Date _____