CASE HISTORY

Name: ______________________ Date: __________ Birth Date: __________ Age: ______

Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Sex: ☐M ☐F

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed #of Children __________

Social Security#: ______________________

Occupation: ______________________ Employer: ______________________

Spouse's Name: ______________________ Spouse's Occupation: ______________________

Emergency Contact Name & Phone: ____

	Reason for appointment & related health problems	Date condition started or for how long	Previous Episodes	Injury Related
1.	____________	____________	____________	YES / NO
2.	____________	____________	____________	YES / NO
3.	____________	____________	____________	YES / NO

Please write the area of complaint on the line and Circle the intensity of your pain today.

1= No Pain 10= Most Intense Pain Imaginable

Example ________ Neck ________

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

HABITS

☐ Smoking Packs/Day: __________

☐ Drinking Alcohol: __________

☐ Coffee Cups/Day: __________

EXERCISE

☐ None

☐ Moderate

☐ Daily

Type: ______________________

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐

Who may we thank for referring you to us? ______________________

Current Medications (prescription or over-the-counter): ______________________

____

Medical Doctor consulted in the past year:

Name: ______________________ Approxiamted Date of Last Visit __________

Name: ______________________ Approxiamted Date of Last Visit __________

Chiropractic Doctor consulted in the past year:

Name: ______________________ Approxiamted Date of Last Visit __________

Name: ______________________ Approxiamted Date of Last Visit __________

Have you had X-rays taken? ☐Yes ☐ No When? __________ By Whom? __________

For what ailments were these X-rays taken? ______________________

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ Appendicitis	☐ Anemia	☐ Polio	☐ Pneumonia	☐ Measles
☐ Goiter	☐ Rheumatic Fever	☐ Mumps	☐ Influenza	☐ Heart Disease
☐ Chicken Pox	☐ Pleurisy	☐ Tuberculosis	☐ Diabetes	☐ Alcoholism
☐ Whooping Cough	☐ HIV Positive	☐ Eczema	☐ Veneral Disease	☐ Lumbago
☐ Cancer	☐ Mental Disorder	☐ Epilepsy	☐ Arthritis	☐ Other_________________

Please circle any conditions you may have had in the past or have now:

GENERAL SYMPTOMS
Allergy____________________
____
Bronchitis
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Headache
Loss Of Sleep
Loss Of Weight
Nervousness
Neuralgia
Night Sweats
Wheezing
Numbness or Pain in arms/legs/hands

G/I
Belching or Gas
Colon Trouble
Constipation
Diarrhea
Excessive Hunger
Gall Bladder
Hemorrhoids
Jaundice
Liver Trouble
Nausea
Pain over stomach
Poor Appetite
Poor Digestion
Vomiting
Vomiting Blood

EENT
Asthma
Crossed Eyes
Deafness
Earache
Ear Discharge
Ear Noises
Enlarged Thyroid
Frequent Colds
Hay Fever
Hoarseness
Nasal Obstruction
Nose Bleeds
Pain in the eyes
Poor Vision
Sinusitis
Sore Throats
Tonsillitis

RESPIRATORY
Chest Pain
Chronic Cough
Difficulty Breathing
Spitting Blood
Spitting Phlegm

G/U
Bed-wetting
Blood in Urine
Frequent Urination
Inability to control urine
Painful Urination
Prostate Trouble
Kidney Infection

MUSCULOSKELETAL
Backache
Foot Trouble
Hernia
Pain between shoulders
Tremors
Painful Tailbone
Stiff Neck
Spinal Curvature
Twitching
Swollen Joints

C/V
High Blood Pressure
Low Blood Pressure
Pain over heart
Poor Circulation
Stroke
Swollen Ankles
Rapid Heart Rate
Slow Heart Rate
Varicose Veins
Previous Heart Trouble

SKIN
Boils
Bruising Easily
Dryness
Eczema
Hives or Allergy
Itching
Sensitive Skin
Skin Eruptions

FOR WOMEN ONLY
Cramps or Backaches
Excessive Flow
Hot Flashes
Irregular Cycle
Miscarriage
Painful Periods
Vaginal Discharge
Pregnant Currently?
☐Yes ☐No

OPERATIONS AND PROCEDURES

Date	Date	Date
_____________Vaccinations	_____________Tubes in Ears	_____________Sinus
_____________Tonsillectomy	_____________Appendectomy	_____________Hernia
_____________Gall Bladder	_____________Female Organs	_____________Other:_____________
_____________Back Operation	_____________Rectal Surgery	_____________Other:_____________
_____________Thyroid	_____________Stomach	☐I have never had any operations

Please list any accidents and/or falls and their corresponding dates:____
____

Please list any broken bones/fractures/dislocations:____
____

Spinal Taps/Injections: ☐Yes ☐No Knocked Unconcious: ☐Yes ☐No Lapse of Memory: ☐Yes ☐No

I understand and agree that health and accident insurance policies are an agreement 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 makng the collection myself from the insurance company. However, I clearly understand and agreee that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that payment is due after completion of professional services rendered to me. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Care, and I give authroity for these procedures to be performed.

Patient/Guardian Signature: X____Date:______________________