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 2. _____ Began-(Mo/Yr): Previous Episodes:
severity) 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 2 3 4 5 6 8 9 10

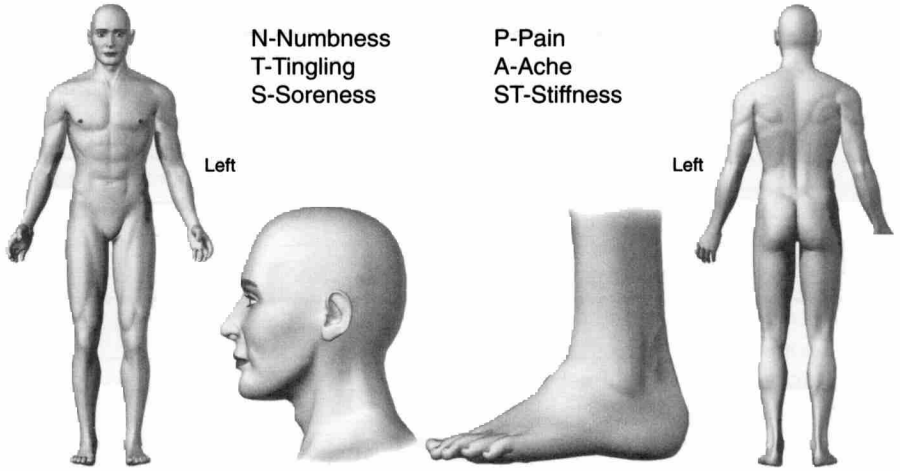
2. _____
O 2 3 4 5 6 7 8 9 10

3. _____
O 1 2 3 4 5 6 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



DOCTORS USE ONLY

_____
_____
_____
_____

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	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother,# of: ___	❑	❑	❑	❑	❑
Sister,# of: ___	❑	❑	❑	❑	❑

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 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	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

(OVER)