

CASE HISTORY

Name _____ Date _____
 Date of Birth _____ Age _____ Sex: M or F Marital Status: S M D W
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
 Home Address _____ City _____ State _____ Zip _____
 Occupation _____ Employer _____
 Social Security # _____ Driver's License _____ E~mail _____
 Spouse's Name _____ Spouse's Phone (work) (____) _____
 Relative Not in Household _____ Relationship _____ Phone _____
 Person Responsible for Account _____ Relationship _____
 Referred to this office by _____ Past Chiropractic Care: Yes No When _____

INSURANCE INFORMATION

Please plan to present your insurance card to the front desk assistant.

If insured is other than the patient:

Insured's Name _____ Date of Birth _____
 Employer _____ Work Phone _____

Please list the problems you are seeing us for and circle a pain indicator.

<u>Chief Complaint</u>	<u>Pain scale: (0 = no pain, 10 = extreme pain)</u>
1. _____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
2. _____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
3. _____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
4. _____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Other doctors seen for this condition and when? _____

What was the treatment? _____

What were the results? _____

Are your present problems due to an injury? Yes No On the job Auto Accident Other _____
 Has the accident been reported? Yes No Employer Auto Carrier Worker's Comp Other _____
 Are you now, or have you ever been disabled? (Service/Work) Yes No - When? _____
 Have you retained an attorney? Yes No - Name _____ Phone _____
 Attorney's address _____ City _____ State _____ Zip _____

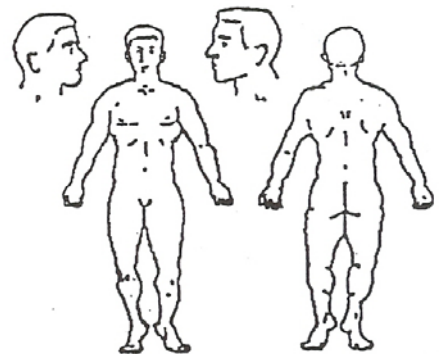
Please give most current date:

Spinal Exam _____	<u>MALES ONLY</u>
Disc. Exam _____	Prostate Exam _____
Lab Exam _____	<u>FEMALES ONLY</u>
Last Physical _____	Pap Smear _____
	Breast Exam _____

Current Weight _____
 Current Height _____

Mark Pain Area

N= Numbness
 P= Sharp Pain
 T= Tingling
 B= Burning
 D= Dull Pain
 S= Stiffness



Family History

<u>Habits</u>	<u>Amount of Exercise</u>	<u>Diabetes</u>	<u>Heart</u>	<u>Kidney</u>	<u>Cancer</u>	<u>Scoliosis</u>
<input type="checkbox"/> Alcohol drinks/week _____	<input type="checkbox"/> Moderate	Father <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coffee Cups/day _____	<input type="checkbox"/> Daily	Mother <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Smoking Packs/day _____	<input type="checkbox"/> None	Siblings <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE CHECK THE DISEASES YOU HAVE HAD

- | | | | | |
|-----------------------------------|--|--|---|---------------------------------------|
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Venereal Infection | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | |

Cancer: Where _____ Current Status _____

MARK ANY OF THE FOLLOWING YOU HAVE HAD IN *THE LAST 6 MONTHS*:

- | | | | | |
|--------------------------------|---------------------------------|-----------------------------------|-------------------------------|----------------------------------|
| <u>General Symptoms</u> | <u>Gastro-Intestinal</u> | <u>Eye/Ear/Nose/Throat</u> | <u>Respiratory</u> | <u>Muscles and Joints</u> |
| __ Headache | __ Poor Appetite | __ Poor Vision | __ Chronic Cough | __ Weakness |
| __ Fever/Chills | __ Poor Digestion | __ Pain in Eyes | __ Spitting Blood | __ Twitching |
| __ Night Sweats | __ Excessive Hunger | __ Deafness | __ Spitting Phlegm | __ Stiff Neck |
| __ Fainting | __ Nausea/Vomiting | __ Earache | __ Chest Pain | __ Backache |
| __ Dizziness/Vertigo | __ Vomiting Blood | __ Ear Noises | <u>Genito-Urinary</u> | __ Hernia |
| __ Convulsions | __ Pain over Stomach | __ Nose Bleeds | __ Frequent Urination | __ Swollen Joints |
| __ Loss of Sleep | __ Constipation | __ Asthma | __ Painful Urination | __ Tremors |
| __ Fatigue | __ Diarrhea | __ Frequent Colds | __ Blood in Urine | |
| __ Nervousness | __ Liver Trouble | __ Enlarged Thyroid | __ Kidney Infection | |
| __ Numbness/ pain in | __ Gall Bladder | __ Tonsillitis | __ Bed Wetting | |
| Arms/Legs/Hands | Trouble | __ Sinus Trouble | __ Inability to control Urine | |
| __ Neuralgia | | __ Wheezing | __ Prostate Trouble | |
| __ Allergy _____ | | | | |

- | | | | |
|--|---------------------------------|------------------------------|--|
| <u>Cardio Vascular</u> | <u>Skin or Allergies</u> | <u>FOR WOMEN ONLY</u> | <u>CANCER WARNING SIGNALS</u> |
| __ Rapid Heart | __ Skin Eruptions | __ Painful Periods | <input type="checkbox"/> Change in bladder/bowel habit |
| __ Slow Heart | __ Itching | __ Excessive Flow | <input type="checkbox"/> Sore that does not heal |
| __ Heart Murmur | __ Bruising Easily | __ Irregular Cycle | <input type="checkbox"/> Unusual bleeding/discharge |
| __ High Blood Pressure | __ Dryness | __ Hot Flashes | <input type="checkbox"/> Change in wart/mole |
| __ Low Blood Pressure | __ Hives or Allergy | __ Cramps | <input type="checkbox"/> Indigestion/difficulty swallowing |
| __ Pain Over Heart | __ Eczema | __ Backache | <input type="checkbox"/> Unexplained weight loss |
| __ Previous Heart Trouble | __ Food Allergies | <u>PREGNANT NOW?</u> | <input type="checkbox"/> Nagging cough/hoarseness |
| __ Strokes | _____ | Due Date _____ | |
| __ Swelling Ankles | __ Medicine Allergies | | |
| __ Poor Circulation/
Varicose Veins | _____ | | |

List any surgery or hospitalization (give dates) _____

List any accidents or falls (give dates) _____

List any broken bones (fractures) or dislocations _____

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 had X-rays taken in the last 2 years? 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? _____

List any medications you are now taking – prescription and over-the-counter: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand the Doctor's office will prepare any necessary reports and forms to assist me in collection from the insurance company. Any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. I understand and agree that all services rendered me are charged to me and I am personally responsible for payment. I understand if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand should my case need to go to collection, there will be an additional 18% charge per annum.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. It is understood and agreed the amount paid for the x-rays is for examination only and the x-ray negatives remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature _____ Date _____