CASE HISTORY

Name _____ **Date** _____

Date of Birth _____ **Age** _____ **Sex:** ☐**M** ☐ **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.

Chief Complaint	Pain scale: (0 = no pain, 10 = extreme pain)
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 _____
Disc. Exam _____
Lab Exam _____
Last Physical _____

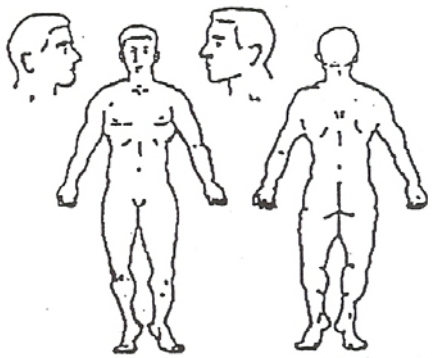
MALES ONLY
Prostate Exam _____

FEMALES ONLY
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



Habits		Amount of Exercise
☐Alcohol	drinks/week _____	☐Moderate
☐Coffee	Cups/day _____	☐Daily
☐Smoking	Packs/day _____	☐None

Family History

	Diabetes	Heart	Kidney	Cancer	Scoliosis
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐

PLEASE CHECK THE DISEASES YOU HAVE HAD

☐Goiter	☐Heart Disease	☐Anemia	☐Alcoholism	☐Osteoporosis
☐Polio	☐Pleurisy	☐Arthritis	☐AIDS	☐Scoliosis
☐Epilepsy	☐Rheumatic Fever	☐Mental Disorder	☐Venereal Infection	
☐Diabetes	☐Tuberculosis	☐Depression	☐Hepatitis	

☐Cancer: Where _____ Current Status _____

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

General Symptoms
__Headache
__Fever/Chills
__Night Sweats
__Fainting
__Dizziness/Vertigo
__Convulsions
__Loss of Sleep
__Fatigue
__Nervousness
__Numbness/ pain in Arms/Legs/Hands
__Neuralgia
__Allergy _____

Gastro-Intestinal
__Poor Appetite
__Poor Digestion
__Excessive Hunger
__Nausea/Vomiting
__Vomiting Blood
__Pain over Stomach
__Constipation
__Diarrhea
__Liver Trouble
__Gall Bladder Trouble

Eye/Ear/Nose/Throat
__Poor Vision
__Pain in Eyes
__Deafness
__Earache
__Ear Noises
__Nose Bleeds
__Asthma
__Frequent Colds
__Enlarged Thyroid
__Tonsillitis
__Sinus Trouble
__Wheezing

Respiratory
__Chronic Cough
__Spitting Blood
__Spitting Phlegm
__Chest Pain

Genito-Urinary
__Frequent Urination
__Painful Urination
__Blood in Urine
__Kidney Infection
__Bed Wetting
__Inability to control Urine
__Prostate Trouble

Muscles and Joints
__Weakness
__Twitching
__Stiff Neck
__Backache
__Hernia
__Swollen Joints
__Tremors

Cardio Vascular
__Rapid Heart
__Slow Heart
__Heart Murmur
__High Blood Pressure
__Low Blood Pressure
__Pain Over Heart
__Previous Heart Trouble
__Strokes
__Swelling Ankles
__Poor Circulation/ Varicose Veins

Skin or Allergies
__Skin Eruptions
__Itching
__Bruising Easily
__Dryness
__Hives or Allergy
__Eczema
__Food Allergies
_____
__Medicine Allergies
_____

FOR WOMEN ONLY
__Painful Periods
__Excessive Flow
__Irregular Cycle
__Hot Flashes
__Cramps
__Backache
__PREGNANT NOW?
Due Date _____

CANCER WARNING SIGNALS
☐Change in bladder/bowel habit
☐Sore that does not heal
☐Unusual bleeding/discharge
☐Change in wart/mole
☐Indigestion/difficulty swallowing
☐Unexplained weight loss
☐Nagging cough/hoarseness

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 _____