

# 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 \_\_\_\_\_

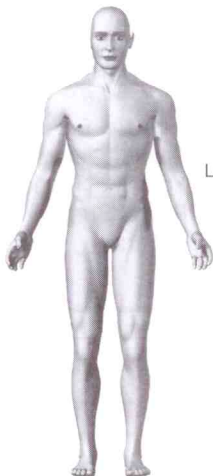
Are your present problems due to an injury?  No  Yes  On the Job  Auto Accident  Personal Injury  Other: \_\_\_\_\_  
 Has the accident been reported?  No  Yes  To Employer  Auto Carrier  Other: \_\_\_\_\_  
 Are you now or have you ever been disabled? (Service or Work)?  No  Yes When? \_\_\_\_\_ Why? \_\_\_\_\_  
 Have you retained an attorney?  No  Yes Name & Address: \_\_\_\_\_

Pain Symptoms: 1. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 (in order of severity) 2. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 3. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_

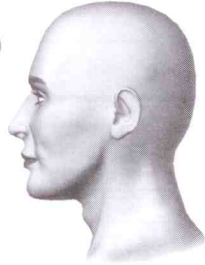

**Please mark the intensity of your pain today.**  
 0 - NO PAIN  
 10 - INTENSE PAIN  
 Example Neck  
 O 1 2 3 4 5 6 7 8 9 10  
 ④  
 1. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10  
 2. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10  
 3. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10

**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
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Left

Left



**DOCTORS USE ONLY**

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**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Brother, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sister, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

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

<input type="checkbox"/> 541 Appendicitis	<input type="checkbox"/> 280 Anemia	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 716 Arthritis
<input type="checkbox"/> 480 Pneumonia	<input type="checkbox"/> 055 Measles	<input type="checkbox"/> 240 Goiter	<input type="checkbox"/> 345 Epilepsy
<input type="checkbox"/> 390 Rheumatic Fever	<input type="checkbox"/> 072 Mumps	<input type="checkbox"/> 487 Influenza	<input type="checkbox"/> 319 Mental Disorder
<input type="checkbox"/> 045 Polio	<input type="checkbox"/> 052 Chicken Pox	<input type="checkbox"/> 511 Pleurisy	<input type="checkbox"/> 724.2 Lumbago
<input type="checkbox"/> 011 Tuberculosis	<input type="checkbox"/> 250 Diabetes	<input type="checkbox"/> 303.9 Alcoholism	<input type="checkbox"/> 690 Eczema
<input type="checkbox"/> 033 Whooping Cough	<input type="checkbox"/> 239 Cancer	<input type="checkbox"/> 099 Venereal Disease	<input type="checkbox"/> 042 HIV Positive
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 346.9 Migraine Headaches	<input type="checkbox"/> 054.9 Herpes	<input type="checkbox"/> 340 Multiple Sclerosis

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T-Tingling  
S-Soreness

P-Pain  
A-Ache  
ST-Stiffness

Left Left

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Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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