# 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: (in order of severity)
1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

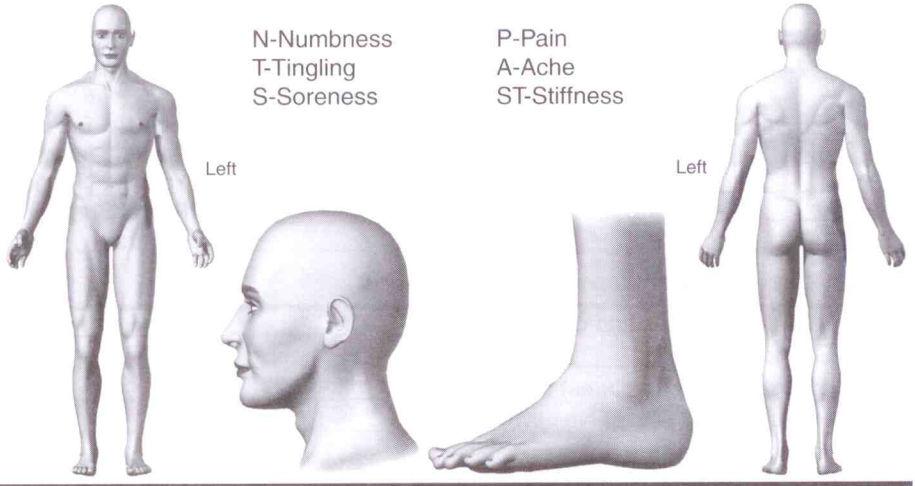
**Please mark the intensity of your pain today.**
0 - NO PAIN
10 - INTENSE PAIN
Example _____ Neck _____
O 1 2 3 ④ 5 6 7 8 9 10

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




**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)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

| Never | Previously | Presently | GENERAL SYMPTOMS | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 995.3 | Allergy (What)____ |
| ❑ | ❑ | ❑ | 490 | Bronchitis |
| ❑ | ❑ | ❑ | 780.9 | Chills |
| ❑ | ❑ | ❑ | 780.39 | Convulsions |
| ❑ | ❑ | ❑ | 780.4 | Dizziness |
| ❑ | ❑ | ❑ | 780.2 | Fainting |
| ❑ | ❑ | ❑ | 780.79 | Fatigue |
| ❑ | ❑ | ❑ | 780.6 | Fever |
| ❑ | ❑ | ❑ | 784.0 | Headache |
| ❑ | ❑ | ❑ | 780.52 | Loss of Sleep |
| ❑ | ❑ | ❑ | 783 | Loss of Weight |
| ❑ | ❑ | ❑ | 799.2 | Nervousness |
| ❑ | ❑ | ❑ | 729.2 | Neuralgia |
| ❑ | ❑ | ❑ | 780.8 | Sweats |
| ❑ | ❑ | ❑ | 786.07 | Wheezing |
| ❑ | ❑ | ❑ | 311 | Depression |

| Never | Previously | Presently | GASTRO-INTESTINAL | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 787.3 | Belching/Gas/Bloating |
| ❑ | ❑ | ❑ | 789.0 | Abdominal Pain |
| ❑ | ❑ | ❑ | 564.0 | Constipation |
| ❑ | ❑ | ❑ | 787.91 | Diarrhea |
| ❑ | ❑ | ❑ | 783.6 | Excessive Eating |
| ❑ | ❑ | ❑ | 575.9 | Gall Bladder Trouble |
| ❑ | ❑ | ❑ | 455 | Hemorrhoids (piles) |
| ❑ | ❑ | ❑ | 782.4 | Jaundice |
| ❑ | ❑ | ❑ | 794.8 | Liver Trouble |
| ❑ | ❑ | ❑ | 787.02 | Nausea |
| ❑ | ❑ | ❑ | 536.9 | Stomach Pain |
| ❑ | ❑ | ❑ | 783.0 | Poor Appetite |
| ❑ | ❑ | ❑ | 536.8 | Poor Digestion |
| ❑ | ❑ | ❑ | 787.03 | Vomiting |
| ❑ | ❑ | ❑ | 578.0 | Vomiting Blood |
| ❑ | ❑ | ❑ | 783.5 | Excessive Thirst |
| ❑ | ❑ | ❑ | 536.8 | Indigestion |
| ❑ | ❑ | ❑ | 569.3 | Rectal Bleeding |

| Never | Previously | Presently | EYE/EAR/NOISE/THROAT | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 493.9 | Asthma |
| ❑ | ❑ | ❑ | 378.9 | Crossed Eyes |
| ❑ | ❑ | ❑ | 389.9 | Deafness |
| ❑ | ❑ | ❑ | 388.70 | Earache |
| ❑ | ❑ | ❑ | 388.60 | Ear Discharge |
| ❑ | ❑ | ❑ | 388.30 | Ear Noises |
| ❑ | ❑ | ❑ | 240.9 | Enlarged Thyroid |
| ❑ | ❑ | ❑ | 460 | Frequent Colds |
| ❑ | ❑ | ❑ | 477 | Hay Fever |
| ❑ | ❑ | ❑ | 784.49 | Hoarseness |
| ❑ | ❑ | ❑ | 478.1 | Nasal Obstruction |
| ❑ | ❑ | ❑ | 784.7 | Nosebleeds |
| ❑ | ❑ | ❑ | 379.91 | Pain in Eyes |
| ❑ | ❑ | ❑ | 368.9 | Poor Vision |
| ❑ | ❑ | ❑ | 461.9 | Sinusitis |
| ❑ | ❑ | ❑ | 462 | Sore Throat |
| ❑ | ❑ | ❑ | 463 | Tonsillitis |
| ❑ | ❑ | ❑ | 786.2 | Persistent Cough |
| ❑ | ❑ | ❑ | 787.2 | Difficulty Swallowing |
| ❑ | ❑ | ❑ | 523.8 | Bleeding Gums |

| Never | Previously | Presently | RESPIRATORY | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 786.50 | Chest Pain |
| ❑ | ❑ | ❑ | 786.2 | Chronic Cough |
| ❑ | ❑ | ❑ | 786.09 | Difficulty Breathing |
| ❑ | ❑ | ❑ | 786.3 | Spitting Blood |
| ❑ | ❑ | ❑ | 786.4 | Spitting Phlegm |

**GENITO-URINARY**

| | | | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 788.36 | Bed Wetting |
| ❑ | ❑ | ❑ | 599.7 | Blood in Urine |
| ❑ | ❑ | ❑ | 788.4 | Frequent Urination |
| ❑ | ❑ | ❑ | 788.3 | Lack of Bladder Control |
| ❑ | ❑ | ❑ | 590.9 | Kidney Infection |
| ❑ | ❑ | ❑ | 788.1 | Painful Urination |
| ❑ | ❑ | ❑ | 601.9 | Prostate Trouble |

| | | | MUSCLES/JOINTS/BONES | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 724.5 | Backache |
| ❑ | ❑ | ❑ | 719.7 | Foot Trouble |
| ❑ | ❑ | ❑ | 550 | Hernia |
| ❑ | ❑ | ❑ | 719.1 | Pain Between Shoulders |
| ❑ | ❑ | ❑ | 724.6 | Painful Tail Bone |
| ❑ | ❑ | ❑ | 723.9 | Stiff Neck |
| ❑ | ❑ | ❑ | 781.9 | Spinal Curvature |
| ❑ | ❑ | ❑ | 719.0 | Swollen Joints |
| ❑ | ❑ | ❑ | 781.0 | Tremors/Twitching |
| ❑ | ❑ | ❑ | 782 | Arm Trouble |

| | | | CARDIO-VASCULAR | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 401.9 | High Blood Pressure |
| ❑ | ❑ | ❑ | 458.9 | Low Blood Pressure |
| ❑ | ❑ | ❑ | 786.51 | Pain Over Heart |
| ❑ | ❑ | ❑ | 785.9 | Poor Circulation |
| ❑ | ❑ | ❑ | 438 | Previous Heart Trouble |
| ❑ | ❑ | ❑ | 785.0 | Rapid Heart |
| ❑ | ❑ | ❑ | 427.89 | Slow Heart |
| ❑ | ❑ | ❑ | 436 | Strokes |
| ❑ | ❑ | ❑ | 719.7 | Swelling Ankles |
| ❑ | ❑ | ❑ | 454 | Varicose Veins |

| | | | SKIN OR ALLERGIES | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 680.9 | Boils |
| ❑ | ❑ | ❑ | 924.9 | Bruising Easily |
| ❑ | ❑ | ❑ | 701.1 | Dryness |
| ❑ | ❑ | ❑ | 691.8 | Eczema |
| ❑ | ❑ | ❑ | 708.9 | Hives or Allergy |
| ❑ | ❑ | ❑ | 698.9 | Itching |
| ❑ | ❑ | ❑ | 782.0 | Sensitive Skin |
| ❑ | ❑ | ❑ | 782.1 | Skin Eruptions |

| | | | FOR WOMEN ONLY | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 625.3 | Cramps or Backaches |
| ❑ | ❑ | ❑ | 626.2 | Excessive Flow |
| ❑ | ❑ | ❑ | 627.2 | Hot Flashes |
| ❑ | ❑ | ❑ | 626.4 | Irregular Cycle |
| ❑ | ❑ | ❑ | 634.9 | Miscarriage |
| ❑ | ❑ | ❑ | 625.3 | Painful Periods |
| ❑ | ❑ | ❑ | 623.5 | Vaginal Discharge |
| ❑ | ❑ | ❑ | 611.79 | Lump in Breast |
| ❑ Yes ❑ No | | | | Pregnant at this time? |
| ❑ Yes ❑ No | | | | Have you had a mammogram? |
| _____ | | | | Last Pap Smear Date |
| _____ | | | | By Whom |

## OPERATIONS AND PROCEDURES

| DATE | | DATE | | DATE | |
|---|---|---|---|---|---|
| _____ | Vaccinations | _____ | Tubes in Ears | _____ | Sinus |
| _____ | Tonsillectomy | _____ | Appendectomy | _____ | Hernia |
| _____ | Gall Bladder | _____ | Female Organs | _____ | Thyroid |
| _____ | Back Operation | _____ | Rectal Surgery | _____ | Stomach |
| _____ | Other: _____ | _____ | Other: _____ | _____ | Other: _____ |

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:_____ ❑ Recreation: _____
❑ Sports:_____ ❑ School:_____ ❑ Other:_____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? ❑ Yes ❑ No Why? _____
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 ever had X-rays taken? ❑ 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? _____
Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No What drugs?_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____