

CASE HISTORY

Name _____ Age _____ Date _____
Address _____ City _____ State _____ Zip _____
Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
Social Security # _____ Driver's License # _____
Occupation _____ Employer _____ Phone (Work) _____
Insurance Company _____ Telephone _____
Insured's Name _____ Insured's Date of Birth _____
Insured's I.D. # or S.S. # _____
Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer _____ Spouse's Phone (Work) _____
Spouse's Insurance Co. _____ Telephone _____
Spouse's Social Security # _____
Referred by _____

Are your present problems due to an injury? () Yes () No
() On the Job () Auto Accident () Personal Injury () Other _____

Has the accident been reported? () Yes () No
() To Employer () Auto Carrier () Other _____

Are you now or have you ever been disabled? (Service or Work)? () Yes () No If yes, when? _____

Have you retained an attorney? () Yes () No Name & Address _____

HEALTH REPORT:

Please describe the principal health problems for which you came to the office: _____

List any other doctors seen for this: _____

List any diagnosis(es) and type of treatment(s): _____

Have you had similar accidents or injuries before? () Yes () No If yes, explain: _____

List the names of any relatives that have or have had a similar problem: _____

Have you or any relative received chiropractic treatment previously? () Yes () No
If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? () Yes () No
If yes, explain: _____

Are you currently under medication? () Yes () No If so, what kind? _____

Have you been under medication in the past? () Yes () No If so, what kind? _____

List the approximate dates of any surgery or unusual diseases you have had: _____

HABITS

- Smoking Packs/Day _____
- Alcohol Drinks/Day _____
- Coffee Cups/Day _____

EXERCISE

- None
 - Moderate
 - Daily
- Type _____

FAMILY HISTORY

- | | | | | |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Diabetes | Heart | Kidney | Cancer |
| Mother | <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"/> |
| Brother, # _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sister, # _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please mark each item below for each sign or symptom if you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Ruptures
- Broken Bones

CARDIO-VASCULAR

- Blood Pressure Problems
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EYE/EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain in Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Trouble
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver Trouble
- Nausea
- Pain over Stomach
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Trouble

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Trouble
- Bladder Trouble

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema
- Hives
- Itching
- Sensitive Skin
- Allergy (what)

FOR WOMEN ONLY

- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time
 - Yes
 - No

Please mark area & type of pain on the drawings using the code listed below

N—Numbness	P—Pain
T—Tingling	A—Ache
S—Soreness	ST—Stiffness

Right Left Left Right

In case of emergency, please notify:

Name _____

Address _____

Phone _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account or receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

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 the Doctor for X-rays is for examination only and the X-ray negatives will 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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

PATIENT'S / GUARDIAN'S SIGNATURE

DATE