

CASE HISTORY

Name: _____ Age: _____ Date: _____ Case Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: (H) _____ Cell: _____ e-mail: _____
 Date of Birth: _____ Sex: **M F** Marital Status: **S M D W** Number of Children _____
 Occupation: _____ Employer: _____ Work Phone #: _____
 Work Address: _____ City: _____ State: _____ Zip: _____
 Social Security #: _____
 Name of Insured: _____ Relationship to Patient: _____
 Spouse's Name: _____ Spouse's Occupation: _____
 Spouse's Employer: _____ Spouse's Telephone (Work): _____
 Spouse's Social Security #: _____ Spouse's Date of Birth: _____
 Insurance Company: _____ Insurance Telephone #: _____
 Emergency Contact: _____ Relationship: _____ Contact #: _____
 Past Chiropractic Care: **Y N** When? _____ Doctor's Name: _____
 Results from previous care: _____ Referred By: _____

Are your present problems due to an injury? **Y N** On the job? **Y N** Auto Accident? **Y N** Personal Injury? **Y N** Other? **Y N**
 Has the accident been reported? **Y N** Reported to: **Employer Auto Carrier Other** _____
 Are you now or have you ever been disabled (Service or Work)? **N Y** When? _____ Why? _____
 Have you ever retained an attorney? **N Y** Name and address: _____

Pain Symptoms: 1. _____ Began - (Mo/Yr) _____ Previous Episodes: _____
 (In order of 2. _____ Began - (Mo/Yr) _____ Previous Episodes: _____
 Severity) 3. _____ Began - (Mo/Yr) _____ Previous Episodes: _____

Please mark the intensity of your pain today.
 0 = No Pain 5 = Take Medication
 10 = Severe Pain (Need Hospitalization)

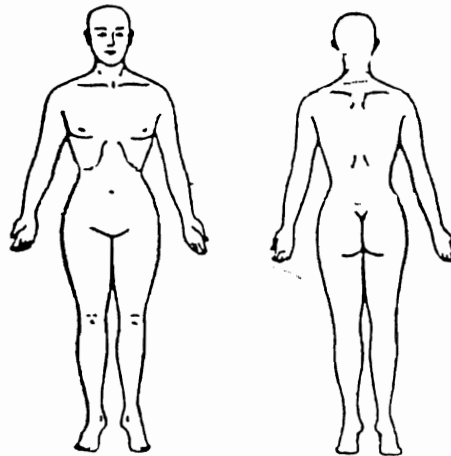
Example Neck
 0 1 2 3 **4** 5 6 7 8 9 10

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

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

HABITS

[] Caffeine Cups/Day: _____
 [] Drinking Alcohol: _____
 [] Smoking Packs/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?

___ Appendicitis	___ Anemia	___ Heart Disease	___ Arthritis	___ Pneumonia	___ Measles
___ Goiter	___ Epilepsy	___ Rheumatic Fever	___ Mumps	___ Influenza	___ Mental Disorder
___ Polio	___ Chicken Pox	___ Pleurisy	___ Tuberculosis	___ Diabetes	___ HIV Positive
___ Alcoholism	___ Eczema	___ Whooping Cough	___ Cancer	___ Venereal Disease	___ Lyme Disease
___ Asthma	___ Migraines	___ Herpes	___ Hepatitis	___ Multiple Sclerosis	

(OVER)