

## 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)

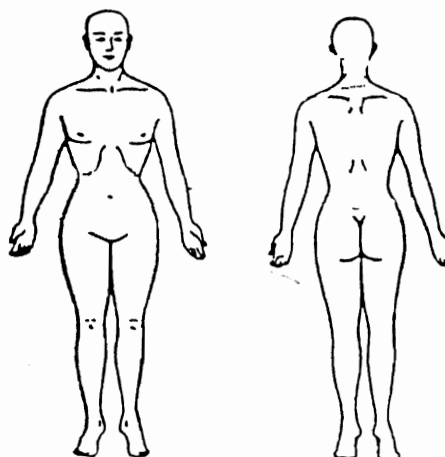
Example Neck  
 0 1 2 3 **4** 5 6 7 8 9 10

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)

**Use the point scale to rate your symptoms based on how you've been feeling over the last 3 months**

0 = **occasionally** have it, effect is **not severe**  
 2 = **occasionally** have it, effect is **severe**

3 = **frequently** have it, effect is **not severe**  
 4 = **frequently** have it, effect is **severe**

**DIGESTIVE TRACT**

- Nausea & Vomiting
- Diarrhea
- Constipation (Less than Daily)
- Bloating Feeling
- Stomach Pains or Cramps
- Heart Burn
- Blood/Mucous in Stools
- Total**

**EARS**

- Itchy Ears
- Ear Aches, Ear Infections
- Drainage from Ear
- Hearing Loss
- Reddening of the Ears
- Ringing in Ears
- Total**

**EMOTIONS**

- Mood Swings
- Anxiety, Fear, Nervousness
- Anger, Irritable, Aggressiveness
- Argumentative
- Frustrated, Cries Easily
- Depression
- Total**

**ENERGY & ACTIVITY**

- Apathy, Lethargy
- Attention Deficit
- Fatigue
- Hyperactivity
- Restlessness
- Shortness of Breath
- Stuttering or Stammering
- Slurred Speech
- Total**

**EYES**

- Watery or Itchy Eyes
- Red, Swollen or Sticky Eyelids
- Bags or Dark Circles under Eyes
- Blurred or Tunnel Vision
- Total**

**HEAD**

- Headaches
- Faintness
- Dizziness
- Insomnia, Sleep Disorder
- Facial Flushing
- Total**

**HEART**

- Irregular or Skipped Heartbeat
- Rapid or Pounding Heartbeat
- Chest Pain
- Total**

**JOINTS & MUSCLES**

- Pains or Aches in Joints
- Arthritis
- Stiffness or Limited Movement
- Pain or Aches in Muscles
- Feeling of Weakness or Tiredness
- Swollen Tender Joints
- Growing Pains in Legs
- Total**

**LUNGS**

- Chest Congestion
- Asthma, Bronchitis
- Itching
- Difficulty in breathing
- Persistent Cough
- Wheezing
- Total**

**MIND**

- Poor Memory
- Difficulty Completing Projects
- Difficulty with Mathematics
- Underachiever
- Poor/Short Attention Span
- Confusion
- Easily Distracted
- Difficulty Making Decisions
- Learning Disabilities
- Total**

**MOUTH & THROAT**

- Chronic Coughing
- Gagging, Often Clearing Throat
- Sore Throat, Hoarse, Voice Loss
- Swollen/Discolored Tongue, Lips
- Canker Sores
- Itching on Roof of Mouth
- Total**

**NOSE**

- Stuffy Nose
- Chronically Red, Inflamed Nose
- Sinus Problems
- Hay Fever
- Sneezing Attacks
- Excessive Mucous Formation
- Total**

**SKIN**

- Acne
- Itching
- Hives, Rash, Dry Skin
- Hair Loss
- Flushing or Hot Flashes
- Total**

**WEIGHT**

- Binge Eating/Drinking
- Craving Certain Foods
- Excessive Weight
- Compulsive Eating
- Water Retention
- Total**

**OTHER**

- Frequent Illness
- Frequent or Urgent Urination
- Genital Itch or Discharge
- Anal Itching
- Total**

**GENERAL**

- Loss of Sleep
- Loss of Weight
- Sweats
- High/Low Blood Pressure
- Pain over Heart
- Gall Bladder Troubles
- Poor Circulation
- Chest Pain
- Spitting Blood
- Bed Wetting
- Blood in Urine
- Lack of Bladder Control
- Lack of Bowel Control
- Prostate Problems

**FOR WOMEN ONLY**

- Poor Physical Condition
- Excessive Flow
- Excessive Flow
- Irregular Cycle
- Painful Period
- Vaginal Discharge
- Lump in Breast

**OPERATIONS AND PROCEDURES**

DATE	DATE	DATE
<input type="checkbox"/> Vaccinations	<input type="checkbox"/> Tubes in Ears	<input type="checkbox"/> Sinus
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Female Organs	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Back Operation	<input type="checkbox"/> Rectal Surgery	<input type="checkbox"/> Stomach
<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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: \_\_\_\_\_

Have you ever had any spinal taps or spinal injections? [ ] Yes [ ] No

Have you ever lost consciousness? [ ] Yes [ ] No Why? \_\_\_\_\_

Have you ever had X-rays taken? [ ] Yes [ ] No When? \_\_\_\_\_ By Whom? \_\_\_\_\_

For what ailment were these X-rays taken? \_\_\_\_\_

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 payments 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 collections 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 of 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** \_\_\_\_\_ **Date** \_\_\_\_\_

## *My Health Goals*

Name \_\_\_\_\_

Date \_\_\_\_\_

Our goal is to fulfill your health care needs. We aim to exceed your expectations.

Let us know if you're looking for just pain relief, rehabilitation, nutritional therapy, allergy desensitization, detoxification, advanced functional diagnostics or comprehensive wellness care.

- Pain relief.
- Pain relief, plus exercise or therapy to avoid a recurrence.
- Identifying and stopping spinal degeneration or decay.
- Comprehensive wellness care to optimize my health...structural, nutritional, detoxification, allergy elimination, electromagnetic protection, emotional well being.
  
- Nutritional Counseling and/or testing
- Allergy Desensitization
- Detoxification
- Mood/Stress/Emotional Balancing
  
- Education/counseling/coaching to prevent or reduce my risk of heart disease, cancer, obesity, diabetes, arthritis.
  
- Laboratory testing for hormone imbalances, digestive problems, toxicity, allergies, neurotransmitters, modifiable genetic factors.  
Specifically: \_\_\_\_\_
  
- Other: \_\_\_\_\_

Please tell us your likes, dislikes or concerns:

	Like	Dislike	Concern
Manual chiropractic adjustments	_____	_____	_____
Activator chiropractic adjustments	_____	_____	_____
Massage therapy	_____	_____	_____
Rehab exercises and stretches	_____	_____	_____
Nutritional supplements	_____	_____	_____
X-rays	_____	_____	_____
Other: _____	_____	_____	_____