

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 _____

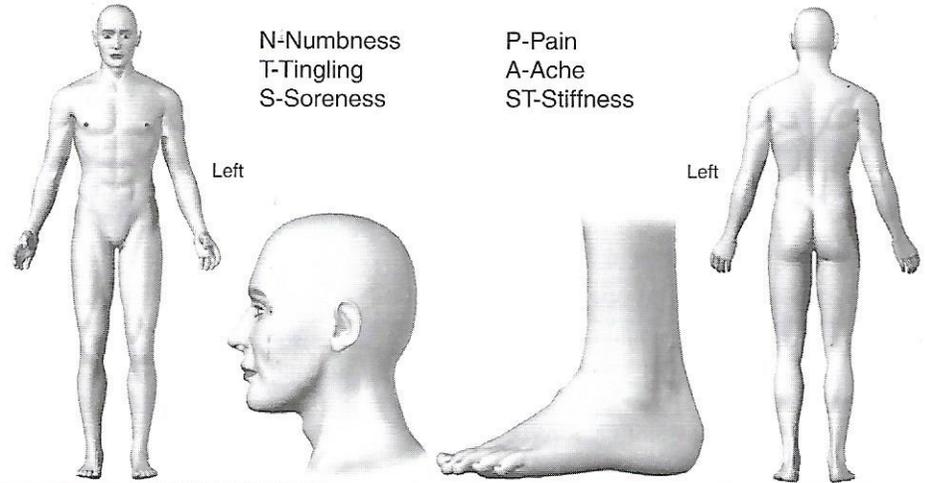
Are your present problems due to an injury? No Yes On the Job Auto Accident Personal Injury Other: _____
 Has the accident been reported? No Yes To Employer Auto Carrier Other: _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When? _____ Why? _____
 Have you retained an attorney?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

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

Please mark the intensity of your pain today.

0 - NO PAIN
 10 - INTENSE PAIN
 Example _____
 O 1 2 3 4 5 6 7 8 9 10
 Neck
 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.



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

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

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td>GENERAL SYMPTOMS</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>995.3 Allergy (What) _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>490 Bronchitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.9 Chills</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.39 Convulsions</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.4 Dizziness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.2 Fainting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.79 Fatigue</td> </tr> <tr> <td><input 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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: _____

CASE HISTORY

1. List Medications you have ever taken and for how long

Drug	Prescribed For	How Long

2. List All Vitamin Supplements' your taking

3. Do you Drink ___ Alcohol How many drinks ___ ___ Coffee How many cups per day ___

4. How do you rate your Stress 1--10 1 little Stress 10 being Very High stress

Scale 1-----10

5. Are you taking Hormones ___Y ___N

6. List any Health Issues such as : Diabetes, surgeries, heart problems etc..

7. Last time you had blood work done or Hormones checked

8. How do you Sleep Poor ___ Fair ___ Good ___

9. How is your digestion Poor ___ Fair ___ Good ___ Not really thought about ___

10. How long have you had back problems? _____

11. Have you consulted with an Alternative Health practitioner for your health? _____

If so what type _____

12. If none of the above applies to you would you be interested in finding out more about your health and ways to keep you healthy? ___Yes ___No