CASE HISTORY

Date__________________ Age _________ Date of Birth_________________
Name____ Sex________
Street Address______________________________________ Marital Status S M D W
City, State, ZIP__________________________ Occupation______________________
Home Phone_______________________ Employer______________________________
Work Phone_______________________ Spouse's Name__________________________
Cell Phone________________________ Spouse's Employer________________________
Have you had past chiropractic care? Y N When?_____________________________
What were the results?____
Primary Doctor's Name_______________________ Your Social Security #_______________
Chief Complaints___________________________ Your Driver's License #_______________
E-Mail Address____________________________
Spouse's Social Security #____________________ Spouse's Driver's License #______________

Are your present problems due to an injury? Y N
If yes, was the injury on the job__________
Auto accident__________
Personal injury________

Have you reported your accident? Y N
If yes, to whom was it reported? Your employer________
Auto insurance________

Has the accident been reported? Y N
If yes, has it been reported to worker's comp_______
Auto insurance_______
Are you now or have you ever been disabled? Y N When?_________________
Have you retained an attorney? Y N
Name and address of attorney____

Please give most current date
Spinal exam___________
Disc exam____________
X-ray exam___________
Lab exam_____________
Last physical__________
Pap smear_____________
Breast exam___________

Smoking Packs/Day_________
Drinking How much per week___________
Coffee Cups/Day__________

Exercise None
Moderate
Daily

Family History	Diabetes	Heart	Kidney	Cancer	Back
Mother	_______	_______	_______	_______	_______
Father	_______	_______	_______	_______	_______
Brothers, Number of_____	_______	_______	_______	_______	_______
Sisters, Number of_______	_______	_______	_______	_______	_______

Please circle if you've had any of the following diseases.

Appendicitis	Pneumonia	Heart Disease	Arthritis	Epilepsy
Measles	Rheumatic Fever	Goiter	Alcoholism	Lumbago
Polio	Mumps	Influenza	Mental Disorder	Eczema
Chicken Pox	Tuberculosis	Pleurisy	AIDS	Venereal Infection
Diabetes	Whooping Cough	Cancer	Anemia	

Please enter "N" for a symptom you're experiencing currently and "P" for a symptom you experienced in the past.

GENERAL SYMPTOMS	MUSCLES & JOINTS	GASTROINTESTINAL
__Headache	__Weakness	__Poor Appetite
__Fever	__Twitching	__Poor Digestion
__Chills	__Stiff Neck	__Excessive Hunger
__Night Sweats	__Backache	__Belching or Gas
__Fainting	__Swollen Joints	__Nausea
__Dizziness	__Tremors	__Vomiting
__Convulsions	__Foot Trouble	__Vomiting Blood
__Loss of sleep	__Painful Tailbone	__Pain over Stomach
__Fatigue	__Pain Between Shoulders	__Constipation

__Nervousness
__Loss of Weight
__Numbness or pain in arms/legs/hands
__Allergy
__Wheezing
__Neuralgia

__Hernia
__Spinal Curvature

__Diarrhea
__Colon Trouble
__Hemorrhoids
__Liver Trouble
__Jaundice
__Gallbladder Trouble

CARDIOVASCULAR
__Rapid Heart
__Slow Heart
__High Blood Pressure
__Low Blood Pressure
__Pain over Heart
__Previous Heart Trouble
__Swelling Ankles
__Poor Circulation
__Varicose Veins
__Strokes

RESPIRATORY
__Chronic Cough
__Spitting Blood
__Spitting Phlegm
__Chest Pain
__Difficulty Breathing

EYE/EAR/NOSE/THROAT
__Poor Vision
__Crossed Eyes
__Pain in Eyes
__Deafness
__Earache
__Ear Noises
__Ear Discharges
__Nasal Obstruction
__Nosebleeds
__Sore Throat
__Hoarseness
__Hay Fever
__Asthma
__Frequent Colds
__Enlarged Thyroid
__Tonsillitis
__Sinus Trouble

SKIN OR ALLERGIES
__Skin Eruptions
__Itching
__Bruising Easily
__Dryness
__Boils
__Sensitive Skin
__Hives or Allergy
__Eczema

GENITOURINARY
__Frequent Urination
__Painful Urination
__Blood in Urine
__Kidney Infection
__Bedwetting
__Inability to Control Urine
__Prostate Trouble

FOR WOMEN ONLY
__Painful Periods
__Excessive Flow
__Irregular Cycle
__Hot Flashes
__Cramps or Backaches
__Miscarriage
__Vaginal Discharge

OPERATIONS & PROCEDURES
DATE PERFORMED
________Vaccinations
________Tonsillectomy
________Gallbladder
________Other
________Female Organs
________Rectal Surgery
________Sinus
________Appendectomy
________Tubes in Ears
________Back Operation
________Stomach
________Thyroid
________Hernia

List any accidents or falls & dates:
Car__________________
Sports__________________
Other__________________
Recreational Vehicle__________________
School__________________________

List any broken bones or dislocations:____
Ever on crutches? Yes No Why?____
Have you ever had any spinal taps or spinal injections? 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 taken?____
Do you suffer from any condition other than that for which you are now consulting us?__________
____

Are you presently taking any medication, either prescription or over-the-counter? Please list.
____
____
____

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 on receipt. I hereby authorize the doctor to examine and treat my conditions as he/she deems appropriate through the use of chiropractic healthcare, 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 Signature____ Date__________________________