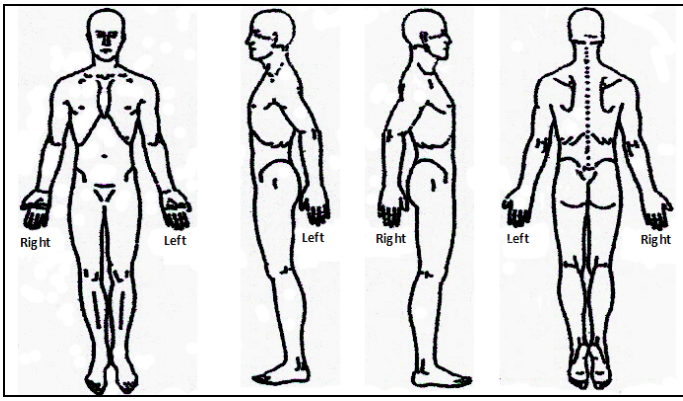
Case History

Name: _____ Age: _____ Date: _____ Case Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Home: _____ Cell: _____ Fax: _____ Email: _____
Date of Birth: _____ Sex: M___ F___ Martial Status: S___ M___ D___ W___ Children:_____
Occupation: _____ Employer: _____ Phone (Work): _____
Spouse's Name: _____ Spouse Occupation: _____
Spouse's Employer: _____ Spouse's Telephone: _____
Past Chiropractic Care? Y___ N___ When? _____ Doctor's name: _____
Results?: _____ Referred by: _____
Drivers License: _____
Chief Complaint: 1._____ Duration: _____ Previous episodes: _____
2._____ Duration: _____ Previous episodes: _____
3._____ Duration: _____ Previous episodes: _____

Are your present problems due to injury? Y___ N ___ On the Job ____ Auto ____ Personal injury ____ Other _____
Has the accident been reported? Y___ N___ To employer____ Auto carrier____ Other_____



Please mark area of pain on drawing using the codes

AAA: Aching **XXX:** Burning **OOO:** Numbness
WWW: Weakness **TTT**: Tingling **////:** Sharp/Stabbing

Circle One: **Constant** **Comes & Goes** **Occasional**

Please mark the intensity of your pain on the scale below

On a scale of 1 to 10; 1 being no pain and 10 being the worst imaginable pain, please mark scale for each area of complaint

Chief Complaint: **(1) 1 2 3 4 5 6 7 8 9 10**
(2) 1 2 3 4 5 6 7 8 9 10
(3) 1 2 3 4 5 6 7 8 9 10

Habits

Smoking ___ Packs/day ___
Drinking ___ Alcohol_ _____
Caffeine ___ Cups/day____

Exercise

None ____
Light activity ____
Mod Activity ____
Active ____
Very Active ____
Elite Athlete ____

Family History

	Diabetes	Heart	Kidney	Cancer	Other
Mother	____	____	____	____	____
Father	____	____	____	____	____
Brother(s)	____	____	____	____	____
Sister(s)	____	____	____	____	____

Other _____

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	___ Lumbago
___ Tuberculosis	___ Diabetes	___ Alcoholism	___ Eczema
___ Whooping cough	___ Cancer	___ Venereal Disease	___ HIV Positive
___ Asthma	___ Herpes	___ Migraine Headaches	

List any accidents or falls and dates: ___ Car _____ Recreation
Sports _____ School _____ Other _____
List any broken bones (fractures) or dislocations: _____ Scars: _____
Ever on Crutches? Y __ N __ Why? _____
Have you ever had any spinal taps or injections? Y ___ N ___ Ever been knocked unconscious? Y ___ N___
Have you ever had a lapse of memory? Y ___ N ___ When? _____ Why? _____
Have you ever had X-rays taken? Y ___ N ___ When? _____ Why? _____
Have you ever been paralyzed? Y ___ N ___ Where? _____ How long? _____
Do you suffer from any condition other than that of which you are consulting us? _____
Are you presently taking any medication- prescription or over the counter? Y ___ N ___ What drugs? _____
_____

Please check all applicable boxes noting Past or Current.

General Symptoms

Past Current
- ☐ ☐ Allergies
- ☐ ☐ Bronchitis
- ☐ ☐ Chills
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Headache
- ☐ ☐ Loss of Sleep
- ☐ ☐ Weight Loss
- ☐ ☐ Nervousness
- ☐ ☐ Neuralgia
- ☐ ☐ Sweats
- ☐ ☐ Wheezing
- ☐ ☐ Depression

Genito-Urinary

Past Current
- ☐ ☐ Bed Wetting
- ☐ ☐ Blood in Urine
- ☐ ☐ Frequent Urination
- ☐ ☐ Lack of Bladder Control
- ☐ ☐ Kidney Infection
- ☐ ☐ Painful Urination
- ☐ ☐ Prostate Troubles

Gastro-Intestinal

Past Current
- ☐ ☐ Gas/Bloating
- ☐ ☐ Abdominal Pain
- ☐ ☐ Constipation
- ☐ ☐ Over Eating
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Jaundice
- ☐ ☐ Liver Trouble
- ☐ ☐ Nausea
- ☐ ☐ Stomach Pain
- ☐ ☐ Poor Appetite
- ☐ ☐ Poor Digestion
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting Blood
- ☐ ☐ Excessive Thirst
- ☐ ☐ Indigestion
- ☐ ☐ Rectal Bleeding

Muscles/Joints/Bones

Past Current
- ☐ ☐ Backache
- ☐ ☐ Foot Trouble
- ☐ ☐ Hernia
- ☐ ☐ Pain btwn Shoulders
- ☐ ☐ Painful Tailbone
- ☐ ☐ Stiff Neck
- ☐ ☐ Spinal Curvature
- ☐ ☐ Swollen Joints
- ☐ ☐ Tremors/Twitching
- ☐ ☐ Arm Trouble

Eye/Ear/Nose/Throat

Past Current
- ☐ ☐ Asthma
- ☐ ☐ Crossed eyes
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear Noises
- ☐ ☐ Enlarges Thyroid
- ☐ ☐ Frequent Colds
- ☐ ☐ Hay Fever
- ☐ ☐ Hoarseness
- ☐ ☐ Nasal Obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Pain in Eyes
- ☐ ☐ Sinusitis
- ☐ ☐ Sore Throat
- ☐ ☐ Persistent Cough
- ☐ ☐ Difficult Swallowing

Cardio/respiratory

Past Current
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Pain Over Heart
- ☐ ☐ Poor Circulation
- ☐ ☐ Previous Heart Trouble
- ☐ ☐ Rapid Heart
- ☐ ☐ Slow Heart
- ☐ ☐ Strokes
- ☐ ☐ Chest
- ☐ ☐ Chronic Cough

Skin/Allergies

Past Current
- ☐ ☐ Boils
- ☐ ☐ Bruising
- ☐ ☐ Dryness
- ☐ ☐ Eczema
- ☐ ☐ Hives
- ☐ ☐ Itching
- ☐ ☐ Sensitive Skin
- ☐ ☐ Eruptions

Women Only

Past Current
- ☐ ☐ Cramps, Backaches
- ☐ ☐ Excessive flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycle
- ☐ ☐ Miscarriage
- ☐ ☐ Painful periods
- ☐ ☐ Vaginal Discharge
- ☐ ☐ Lump in Breast

Yes No

Pregnant Now: ☐ ☐

Have you had a mammogram? ☐ ☐

Date of Last Pap _____

By Whom _____

Operations and Procedures

	Date		Date
Vaccinations:	_____	Gallbladder:	_____
Tonsillectomy:	_____	Appendectomy:	_____
Tubes in Ears:	_____	Hernia:	_____
Sinus:	_____	Female Organs:	_____
Thyroid:	_____	Stomach:	_____
Back Surgery:	_____	Rectal Surgery:	_____
Other:	_____	Other:	_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____

I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid to the doctor for radiographs are for examination only and the radiographs will remain the property of this office being on file where they may be seen at any time while a patient is at this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Signature: _____ Date: _____