CASE HISTORY

Name _____ Age _____ Date _____ Case Number _____

Address _____ City _____ State _____ Zip _____

Phone(Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W #Children _____

Occupation _____ Employer _____ Telephone (Work) _____

Insured's Name _____ Insured's Date of Birth _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Telephone (work) _____

Referred by _____ Past Chiropractic Care ❑Yes ❑ No When _____

Doctor's Name _____ Results _____

Insurance Company _____ Telephone _____

Social Security# _____ Driver's License# _____

Spouse's Insurance Company _____ Telephone _____

Spouse's Social Security# _____ Spouse's Driver's License# _____

Chief Complaint / List Current Problems

1. _____ Duration-(How Long) _____ Previous Episodes ____
2. _____ Duration-(How Long) _____ Previous Episodes ____
3. _____ Duration-(How Long) _____ Previous Episodes ____

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 _____

Have you retained an attorney? ❑ No ❑ Yes Name & Address _____

Please mark the intensity of your pain today

1 — NO PAIN
10 — MOST INTENSE EVER FELT

Example _____ Neck _____
1 2 3 (4) 5 6 7 8 9 10

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

DOCTORS USE ONLY

_____

_____

_____

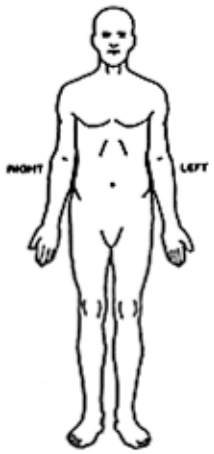
_____

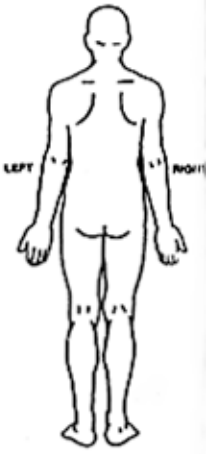
_____

Please mark area & type of pain on the drawings using the code listed below.

N — Numbness
T — Tingling
S — Soreness

P — Pain
A — Ache
ST — Stiffness





HABITS

❑ Smoking Packs/Day _____
❑ Drinking Alcohol _____
❑ Coffee Cups/Day _____

EXERCISE

❑ None
❑ Moderate
❑ Daily

Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother, No. of ____	❑	❑	❑	❑	❑
Sister, No. of ____	❑	❑	❑	❑	❑

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑ 541 Appendicitis
❑ 480 Pneumonia
❑ 390 Rheumatic Fever
❑ 045 Polio
❑ 011 Tuberculosis
❑ 033 Whooping Cough
❑ 280 Anemia
❑ 055 Measles
❑ 072 Mumps
❑ 052 Chicken Pox
❑ 250 Diabetes
❑ 239 Cancer
❑ 429.9 Heart Disease
❑ 240 Goiter
❑ 487 Influenza
❑ 511 Pleurisy
❑ 305.0 Alcoholism
❑ 099 Venereal Infection
❑ 716 Arthritis
❑ 345 Epilepsy
❑ 319 Mental Disorder
❑ 724.2 Lumbago
❑ 690 Eczema
❑ 044 HIV Positive