CASE HISTORY

Account #: ________________

Please complete this form using your keyboard, then print it using the print function of your browser. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

Name: ____ Date: _________

Marital Status: __ Married __ Single __ Divorced __ Widowed

Address: ________________________ City: ____________________ State: _____ Zip: _________

Phone (Home) : _________________________ Phone (Work) : _________________________

Sex: __ Male __ Female Date of Birth: _______ Age: _____ E-mail address: _____________________

Occupation: _________________________ Employer: _______________________________

Spouse's Employer: _________________________ Referred by: _________________________

Your social security number: _________________________ Spouse SS#: _________________________

Have you seen a chiropractor before? __ Yes __ No Chiropractor's name:____________________________

Who is your primary care physician? ____

Reason for your visit today? (Please list areas of pain.)____

Date of accident or beginning of symptoms: ____

Name of emergency contact or nearest relative not living with you: ___________________________________

INSURANCE INFORMATION

Insurance company: _____________________________________ Phone: _______________________

Spouse's insurance company: _____________________________________ Phone: ________________

Are present symptoms due to an injury? __ Yes __ No __ On the job __ Auto Accident __ Personal Injury

Has the accident been reported? __ Yes __ No __ To Worker's Comp? __ To Auto Carrier?

Have you retained an attorney? __ Yes __ No

Name and phone number: ____

SEVERITY OF PAIN

List the area of pain and circle the number below to describe the amount of pain with "1" indicating minor discomfort and "10" representing severe pain.

1. ______________________________ 1 2 3 4 5 6 7 8 9 10

2. ______________________________ 1 2 3 4 5 6 7 8 9 10

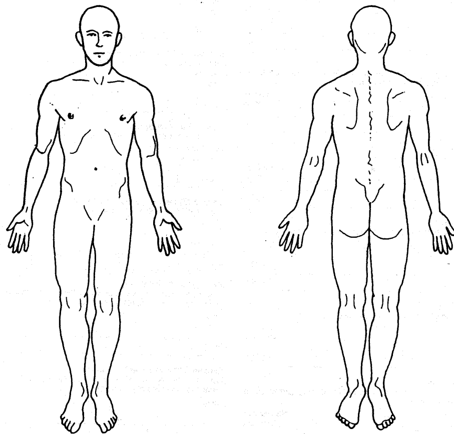
3. ______________________________ 1 2 3 4 5 6 7 8 9 10

4. ______________________________ 1 2 3 4 5 6 7 8 9 10

5. ______________________________ 1 2 3 4 5 6 7 8 9 10

Please mark areas of pain on the drawings using the code listed.

burning (+++)   stabbing (000)   sharp (---)   aching (///)



Please list any concerns about your symptoms and anything else you would like the doctor to know:

____

____

Habits

Smoking: Packs per day _____

Alcohol: Drinks per day ____

Coffee/Tea: Cups per day ____

Vitamins/herbs (list all being taken):

____

Exercise: ___ None ___ Moderate ___ Daily

Family History: Has any member of your family had any of the following diseases?

___ Diabetes ___ Kidney ___ Arthritis ___ Heart ___ Cancer ___ Lung

Have you had any of the following? (Please check or place an "x" in the box.)

	Appendicitis		Heart Disease		Pneumonia
	Polio		Diabetes		Rheumatic Fever
	Anemia		Arthritis		Epilepsy
	Tuberculosis		Hypertension		AIDS
	Cancer		Alcoholism		

Please check or place an "x" for all symptoms that currently apply to you.

General Symptoms	Gastro-Intestinal	EENT	Respiratory
__ Headaches	__ Poor appetite	__ Poor vision	__ Cough
__ Fever	__ Poor digestion	__ Pain in eyes	__ Short of breath
__ Night sweats	__ Excessive hunger	__ Deafness	
__ Fainting	__ Belching or gas	__ Earache	**Genito-Urinary**
__ Dizziness	__ Nausea	__ Ear noises	__ Frequent urination
__ Convulsions	__ Vomiting	__ Nosebleeds	__ Painful urination
__ Loss of sleep	__ Stomach pain	__ Sore throat	__ Blood in urine
__ Fatigue	__ Constipation	__ Hoarseness	__ Kidney infections
__ Loss of weight	__ Diarrhea	__ Hay fever	__ Bed wetting
__ Allergies	__ Hemorrhoids	__ Asthma	__ Incontinence
__ Weakness	__ Liver trouble	__ Frequent colds	__ Prostate trouble
__ Twitching	__ Jaundice	__ Thyroid trouble	__ Bladder infections
	__Gall bladder	__Tonsillitis	
		__Sinus Trouble	

Muscle and Joints	**Cardiovascular**	**Skin**	**For Women Only**
__ Stiff neck	__ Rapid heartbeat	__ Itching	__Painful Periods
__ Neck pain	__ Slow heartbeat	__ Bruise easily	__Excessive Flow
__ Middle back pain	__ High blood pressure	__ Dry skin	__ Irregular cycles
__ Lower back pain	__ Chest pain	__ Boils	__ Hot flashes
__ Arm pain	__ Swollen ankles	__ Sensitive skin	__ Cramps
__ Arm numbness	__ Poor circulation	__ Hives	__ Vaginal discharge
__ Leg pain	__ Varicose veins	__ Eczema	__ Currently pregnant
__ Leg numbness	__ Stroke		__ Breast implants
__ Swollen joints	__ Heart attack		Date of last PAP: _______
__ Painful tailbone			
__ Foot pain			
__ Spinal curvature			

Have you had any of the following surgeries? If yes, please list date.

__ Tonsillectomy	_________	__ Gall bladder	_________	__ Hernia	_________
__ Tubes in ears	_________	__ Stomach	_________	__ Cataract	_________
__ Sinus	_________	__ Appendectomy	_________	__ Vision correction	_________
__ Thyroid	_________	__ Female organs	_________	__ Breast reduction	_________
__ TMJ	_________	__ Hemorrhoids	_________	__ Mastectomy	_________
__ Neck	_________	__ Back	_________	__ Prostate	_________

List any accidents, injuries, falls and dates.

__ Car: ____

__ Sports: ______________________________________

__ School: ______________________________________

__ Other: _______________________________________

List any broken bones or dislocations: ____

Have you ever had a spinal tap or injection? __ Yes __ No

Have you even been knocked unconscious? __ Yes __ No

Have you ever had a lapse in memory? __ Yes __ No

Have you ever had x-rays, MRI or CAT Scan of your spine? __ Yes __ No When? _________________

Do you suffer from any condition other than that for which you are consulting us?___________________________

Are you presently taking any prescription medication? __ Yes __ No If yes, please list:
____

____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _________________________________ Date: ____________