

CASE HISTORY

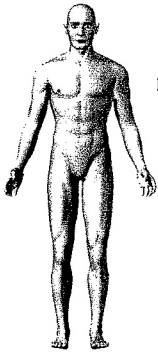
Name: _____ Age: _____ Date: _____ Case Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (Home): _____ **Cell** _____ E-mail: _____
 Date of Birth: _____ Sex: M F Marital Status: S M D W # of Children: _____
 Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
 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: _____
 Chief Complaint: 1. _____ Duration-(How Long): _____ Previous Episodes: _____
 List Current: 2. _____ Duration-(How Long): _____ Previous Episodes: _____
 Problems: 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? _____ Why? _____
 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. _____
 2. _____
 3. _____


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

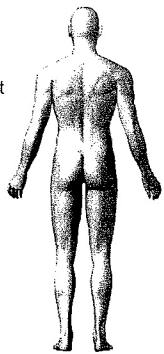
N-Numbness T-Tingling S-Soreness	P-Pain A-Ache ST-Stiffness
--	----------------------------------



Left







Left

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