CASE HISTORY

cell_____

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): _____ Ext.# ____

Insured's Name: _____ Phone: _____ 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 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 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 ❹ 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

DOCTOR USE ONLY

_____

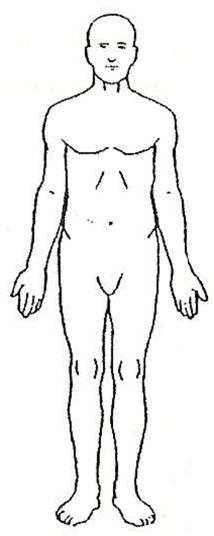
_____

_____

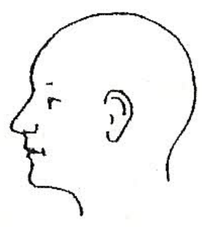
_____

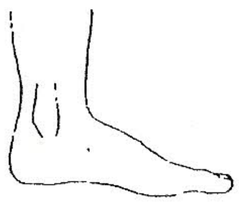
Please mark area & type of pain on the drawings using the codes listed below.

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

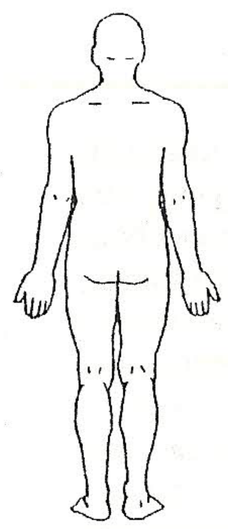


Left





Left



HABITS

☐ Smoking Packs/Day: _____

☐ Drinking Alcohol: _____

☐ Coffee Cups/Day: _____

EXERCISE

☐ None

☐ Moderate

☐ Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, # of ____	☐	☐	☐	☐	☐
Sister, # of ____	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

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

(OVER)