

CASE HISTORY

Name: _____ Age: _____ Date: _____ Case Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: (H) _____ (C) _____ Fax: _____ 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: _____
 Emergency Contact: _____ Relationship _____ Contact Number _____

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: _____

Pain Symptoms: 1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 (in order of 2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 severity) 3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

Please mark the intensity of your pain today.
 0 - NO PAIN
 10 - INTENSE PAIN

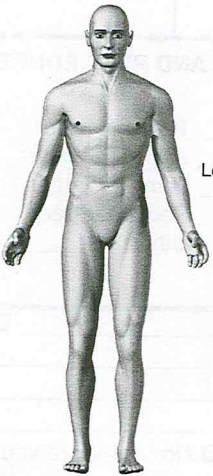
Example _____ Neck _____
 O 1 2 3 ④ 5 6 7 8 9 10

1. _____
 O 1 2 3 4 5 6 7 8 9 10

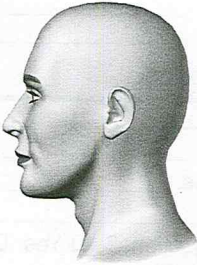
2. _____
 O 1 2 3 4 5 6 7 8 9 10


3. _____
 O 1 2 3 4 5 6 7 8 9 10


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



Left







Left

N-Numbness
 T-Tingling
 S-Soreness

P-Pain
 A-Ache
 ST-Stiffness

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

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. Never Previously Presently.

Never <input type="checkbox"/>	Previously <input type="checkbox"/>	Presently <input type="checkbox"/>	GENERAL SYMPTOMS			Never <input type="checkbox"/>	Previously <input type="checkbox"/>	Presently <input type="checkbox"/>	GASTRO-INTESTINAL			Never <input type="checkbox"/>	Previously <input type="checkbox"/>	Presently <input type="checkbox"/>	EYE/EAR/NOISE/THROAT			Never <input type="checkbox"/>	Previously <input type="checkbox"/>	Presently <input type="checkbox"/>	RESPIRATORY																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	995.3	Allergy (What)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.3	Belching/Gas/Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	493.9	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.50	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.9	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	564.0	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	378.9	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.09	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.4	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	389.9	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.2	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.70	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.79	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.60	Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.6	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.30	Ear Noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.0	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	240.9	Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.52	Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	460	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783	Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	477	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	799.2	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.49	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	729.2	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	478.1	Nasal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.8	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.7	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.07	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	379.91	Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	311	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	368.9	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	578.0	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	461.9	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	575.9	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	462	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.0	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	463	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.0	Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.03	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	578.0	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.5	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	569.3	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>	<input 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type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input 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type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.2	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	523.8	Bleeding Gums	<input type="checkbox"/>