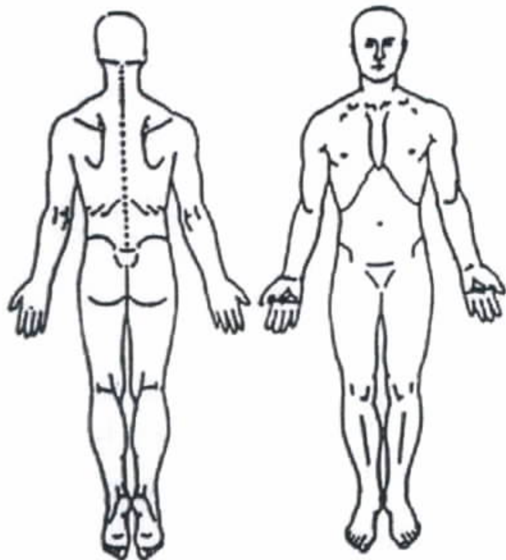
CASE HISTORY

Date ______________________ E-mail ______________________
Name ______________________ Phone (Home) ______________ Date of Birth __________
Address ______________________ Age ________ Sex: M F
______________________ Marital Status: S M D W
Occupation ____________ Employer ______________ Telephone (Work) __________
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 ______________________
Chief Complaint ____
Social Security # ______________________

Are your symptoms: Improving Getting Worse Come and Go Same
Have you had these symptoms before? ☐ Yes ☐ No How long ago? ______________
What aggravates your condition? Standing/Walking Sitting Twisting/Coughing Bending
Have you done anything at home for this? ☐ Yes ☐ No Describe: ______________
Are your present problems due to an injury? ☐ Yes ☐ No ☐ On the job ☐ Auto Accident ☐ Personal Injury ☐ Other
If yes, have you made a report of your accident? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No Name and Address ______________

PLEASE MARK AREA OF PAIN ON THE DRAWING USING THE CODES LISTED

Mark Pain Area
+++ Burning
000 Stabbing
- - - Sharp



SEVERITY OF PAIN

List region of pain and circle severity number.
(1=least, 10=greatest)

III Constant
ex. **Neck**
1 2 3 4 5 6 7 8 9 10

Please list in order of severity.

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

HABITS

☐ Smoking Packs/Day __________
☐ Drinking Alcohol __________
☐ Coffee Cups/Day __________

EXERCISE

☐ None
☐ Moderate
☐ Daily

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 Disease
___ 716 Arthritis
___ 345 Epilepsy
___ 319 Mental Disorder
___ 724.2 Lumbago
___ 690 Eczema
___ 044 AIDS

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of you he will facilitate care.

GENERAL SYMPTOMS

- ____ 784.0 Headache
- ____ 780.6 Fever
- ____ 780.9 Chills
- ____ 780.8 Night Sweats
- ____ 780.2 Fainting
- ____ 780.4 Dizziness
- ____ 780.3 Convulsions
- ____ 780.52 Loss of Sleep
- ____ 780.7 Fatigue
- ____ 799.2 Nervousness
- ____ 783 Loss of Weight
- ____ 782 Numbness or pain in arms/legs/hands
- ____ 995.3 Allergy (What)
- ____ 786.09 Wheezing
- ____ 729.2 Neuralgia

GASTRO-INTESTINAL

- ____ 783 Poor Appetite
- ____ 536.8 Poor Digestion
- ____ 994.2 Excessive Hunger
- ____ 787.3 Belching or Gas
- ____ 787 Nausea
- ____ 787 Vomiting
- ____ 578 Vomiting Blood
- ____ 536.8 Pain over Stomach
- ____ 564 Constipation
- ____ 558.9 Diarrhea
- ____ 789 Colon Trouble
- ____ 455.6 Hemorrhoids (Piles)
- ____ 785.1 Liver Trouble
- ____ 782.4 Jaundice
- ____ 575.9 Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

- ____ 368.9 Poor Vision
- ____ 378.9 Crossed Eyes
- ____ 379.91 Pain in Eyes
- ____ 389.9 Deafness
- ____ 388.70 Earache
- ____ 388.30 Ear Noises
- ____ 388.60 Ear Discharges
- ____ 478.1 Nasal Obstruction
- ____ 784.7 Nose Bleeds
- ____ 462 Sore Throats
- ____ 784.49 Hoarseness
- ____ 477.9 Hay Fever
- ____ 493.9 Asthma
- ____ 460 Frequent Colds
- ____ 240.9 Enlarged Thyroid
- ____ 463 Tonsillitis
- ____ 686.9 Sinus Trouble

RESPIRATORY

- ____ 786.2 Chronic Cough
- ____ 786.3 Spitting Blood
- ____ 933.1 Spitting Phlegm
- ____ 786.50 Chest Pain
- ____ 786.09 Difficulty Breathing

GENITO-URINARY

- ____ 788.3 Frequent Urination
- ____ 788.1 Painful Urination
- ____ 599.7 Blood in Urine
- ____ 592 Kidney Infection
- ____ 788.3 Bed Wetting
- ____ 788.1 Inability to control Urine
- ____ 601.9 Prostate Trouble

MUSCLES & JOINTS

- ____ Weakness
- ____ Twitching
- ____ 847 Stiff Neck
- ____ 722.10 Backache
- ____ 719 Swollen Joints
- ____ 781 Tremors
- ____ 729.5 Foot Trouble
- ____ 724.79 Painful Tail Bone
- ____ 724.5 Pain Between Shoulders
- ____ 563.3 Hernia
- ____ 737.3 Spinal Curvature

CARDIO-VASCULAR

- ____ 783 Rapid Heart
- ____ 427.89 Slow Heart
- ____ 401.9 High Blood Pressure
- ____ 458.9 Low Blood Pressure
- ____ 786.51 Pain over Heart
- ____ 438 Previous Heart Trouble
- ____ 719.07 Swelling Ankles
- ____ 759.9 Poor Circulation
- ____ Varicose Veins
- ____ 436 Strokes

SKIN OR ALLERGIES

- ____ 368.9 Skin Eruptions
- ____ 698.9 Itching
- ____ 278.8 Bruising Easily
- ____ 701.1 Dryness
- ____ Boils
- ____ 782 Sensitive Skin
- ____ 708.9 Hives or Allergy
- ____ 692.9 Eczema
- ____ Medicines ____________ ____________

FOR WOMEN ONLY

- ____ 786.2 Painful Periods
- ____ 626.2 Excessive Flow
- ____ 626.4 Irregular Cycle
- ____ 627.2 Hot Flashes
- ____ 625.3 Cramps or Backache
- ____ 634.9 Miscarriage
- ____ 623.5 Vaginal Discharge
- ____ Pregnant at this Time
- ____ Last Pap

By Whom ____________

Other ____________

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
________	Vaccinations	________	Tubes in Ears	________	Sinus
________	Tonsillectomy	________	Appendectomy	________	Hernia
________	Gall Bladder	________	Female Organs	________	Thyroid
________	Back Operation	________	Rectal Surgery	________	Stomach
________	Other ________ ________		Other ________ ________	________	Other ________ ________

List any accidents or falls and dates: ☐ Car ________ ☐ Recreational Vehicle ________ ☐ Sports ________
☐ School ________ ☐ Other ____________

List any broken bones (fractures) or dislocations: ____________

Ever on crutches? ☐ No ☐ Yes Why? ____________

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ No ☐ Yes When? ________ By whom? ____________

For what ailments were these X-rays made?

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

Are you presently taking any medication - prescription or over-the-counter? ☐ No ☐ Yes What drugs? ____________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, 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 me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X ____________________ Date ____________

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ICE FAMILY HISTORY

FAMILY HISTORY:

Mother: Living ________ Age ______ Present Health Status ____________________

If deceased - At what age ________ Year ______ From What ____________________

Father: Living ________ Age ______ Present Health Status ____________________

If deceased - At what age ________ Year ______ From What ____________________

Any chronic illnesses? ____________________

Other diseases? ____________________

Brothers: Living ________ Age ______ Health Status ____________________

Age ______ Health Status ____________________

Deceased ______ Age ______ Cause of Death ____________________

Age ______ Cause of Death ____________________

Sister: Living ________ Age ______ Health Status ____________________

Age ______ Health Status ____________________

Deceased ______ Age ______ Cause of Death ____________________

Age ______ Cause of Death ____________________

Any chronic illnesses or diseases - Brothers ____________________

Sisters ____________________

MEDICAL HISTORY

Surgical Report: ____________________

____

Hospital Report: ____________________

____

X-Ray Report: ____________________

____

What X-Rays were taken? ____________________

____

How were the X-Rays taken ☐ Sitting ☐ Standing ☐ Laying

Physical Examinations: ____________________

Doctor's Name ____________________

Orthopedic Examinations: ____________________

Doctor's Name ____________________

Neurological Examinations: ____________________

Doctor's Name ____________________

PREGNANCY RELEASE & CONSENT TO DIAGNOSTIC IMAGING

Patient Name:______________________________________ Today's Date: _______________

I understand that if I am pregnant and have X-Rays taken which expose my lower torso and pelvic region to radiation, it is possible to injure my fetus.

I have been advised that the days of a menstrual period of up to 10 days are generally considered to be safe for X-Ray examinations.

With those factors in mind, I am advising my doctor that:

Please check one of the following:

- ❑ I am not pregnant
- ❑ I am pregnant
- ❑ I could be pregnant
- ❑ I am late with my menstrual period
- ❑ I have had a hysterectomy

An X-Ray may be performed on me with my consent.

________________________________ ________________________________

Patient / Guardian Signature Witness Signature