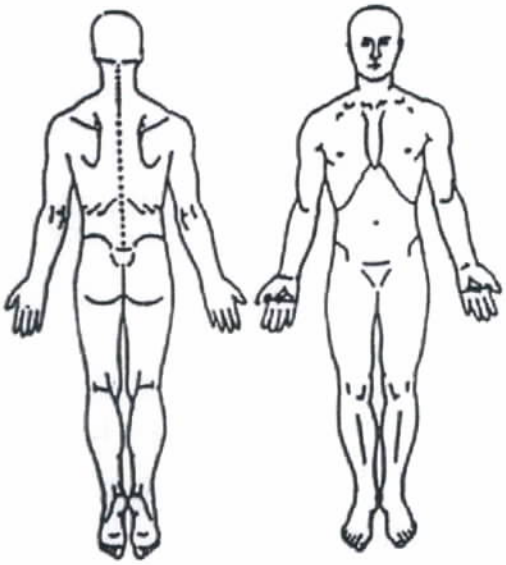
CASE HISTORY

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)

I I I 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 _____

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