# CASE HISTORY

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: _____ **Cell Phone:** _____

**Email:** _____

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 **4** 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**

_____

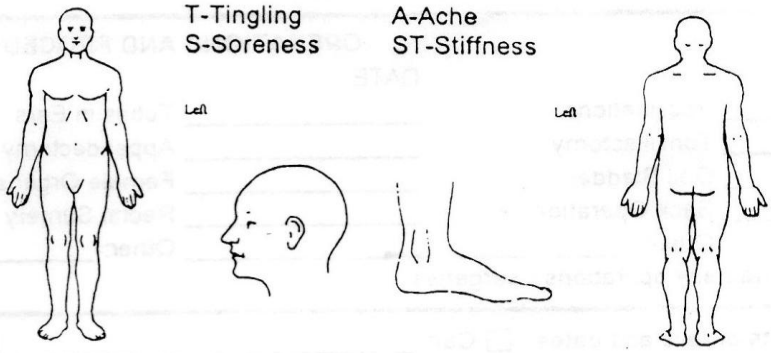
_____

_____

_____

**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




## 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)