# Chiropractic Case History

Name_____________________________________________________________ Date___________________________

Marital Status: ___Married ___Single ___Divorced ___Widowed

Address: _____________________________________ City: ____________________ State: ______Zip: _____________

Phone (Home): ____________________ (Work): ________________________ (Cell): ____________________________

Sex: ___Male ___Female Date of Birth: ____________________________ Age: _________

Patient SSN:______________________________________ E-mail: ___________________________________________

Referred By: _______________________________________ Occupation: ______________________________________

Employer: ________________________________________

Spouse's Name________________________________ Spouse's Employer: _____________________________________

Have you seen a chiropractor before? ___Yes ___No Chiropractor's name: _______________________________________

Who is your primary care physician? ______________________________________________________________________

Reason for your visit today? (Please list areas of pain) _______________________________________________________

Date of accident or beginning of symptoms: _________________________________________________________________

Name and phone # of emergency contact: ____________________________________________________________________

List any broken bones or dislocations: _______________________________________________________________________

Have you ever had a spinal tap or injection? ___Yes ___No Have you ever been knocked unconscious? ___Yes ___No

Have you ever had a lapse in memory? ___Yes ___No

Have you ever had x- rays, MRI, or CAT Scan of your spine? ___Yes ___No When? ________________________________

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

Are you presently taking any prescription medication? ___Yes ___No If yes, please list:
__________________________________________________________________________________________________

Please list any known allergies: __________________________________________________________________________

## Insurance Information

Insurance company : __________________________________ Spouse's Insurance: ___________________________________

Are present symptoms due to an injury? ___Yes ___No ___On the job ___Auto Accident ___ Personal Injury

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
I hereby authorize the doctor to examine me and treat my condition as he deems appropriate through the use of chiropractic health Care. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient Signature: _________________________________________________________ Date: ______________________________

SEVERITY OF PAIN

List the area of pain and circle the number below to describe the amount of pain with "1" indicating minor discomfort and "10" representing severe pain.

1. ______________________________ 1 2 3 4 5 6 7 8 9 10

2. ______________________________ 1 2 3 4 5 6 7 8 9 10

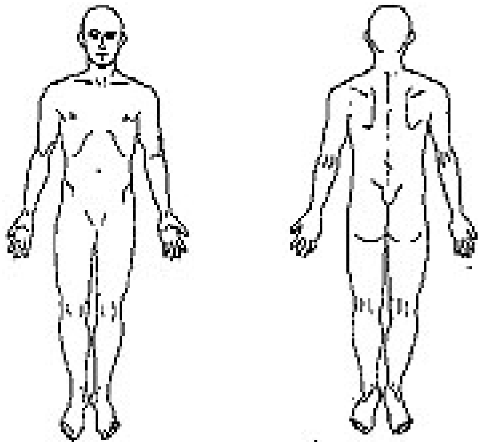
3. ______________________________ 1 2 3 4 5 6 7 8 9 10

4. ______________________________ 1 2 3 4 5 6 7 8 9 10

5. ______________________________ 1 2 3 4 5 6 7 8 9 10

Please mark areas of pain on the drawings using the code listed.

burning (+++) stabbing (000) sharp (---) aching (///)



Please list any concerns about your symptoms and anything else you would like the doctor to know:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Habits

Smoking: Packs per day ______

Alcohol: Drinks per day _____

Coffee/Tea: Cups per day _____

Vitamins/herbs (list all being taken):

______________________________________________________________________

**Exercise:** ___ **None** ___ **Moderate** ___ **Daily**

**Family History:** Has any member of your family had any of the following diseases?

___ Diabetes ___ Kidney ___ Arthritis ___ Heart ___ Cancer ___ Lung

Have you had any of the following? (Please check or place an "x" in the box.)

| | | | | | |
|---|---|---|---|---|---|
| | Appendicitis | | Heart Disease | | Pneumonia |
| | Polio | | Diabetes | | Rheumatic Fever |
| | Anemia | | Arthritis | | Epilepsy |
| | Tuberculosis | | Hypertension | | AIDS |
| | Cancer | | Alcoholism | | |

**Please check or place an "x" for all symptoms that currently apply to you.**

| General Symptoms | Gastro-Intestinal | EENT | Respiratory |
|---|---|---|---|
| __ Headaches | __ Poor appetite | __ Poor vision | __ Cough |
| __ Fever | __ Poor digestion | __ Pain in eyes | __ Short of breath |
| __ Night sweats | __ Excessive hunger | __ Deafness | |
| __ Fainting | __ Belching or gas | __ Earache | **Genito-Urinary** |
| __ Dizziness | __ Nausea | __ Ear noises | __ Frequent urination |
| __ Convulsions | __ Vomiting | __ Nosebleeds | __ Painful urination |
| __ Loss of sleep | __ Stomach pain | __ Sore throat | __ Blood in urine |
| __ Fatigue | __ Constipation | __ Hoarseness | __ Kidney infections |
| __ Loss of weight | __ Diarrhea | __ Hay fever | __ Bed wetting |
| __ Allergies | __ Hemorrhoids | __ Asthma | __ Incontinence |
| __ Weakness | __ Liver trouble | __ Frequent colds | __ Prostate trouble |
| __ Twitching | __ Jaundice | __ Thyroid trouble | __ Bladder infections |
| | __Gall bladder | __Tonsillitis | |
| | | __Sinus Trouble | |

| | | | |
|---|---|---|---|
| Muscle and Joints | Cardiovascular | Skin | For Women Only |
| __ Stiff neck | __ Rapid heartbeat | __ Itching | __ Painful Periods |
| __ Neck pain | __ Slow heartbeat | __ Bruise easily | __ Excessive Flow |
| __ Middle back pain | __ High blood pressure | __ Dry skin | __ Irregular cycles |
| __ Lower back pain | __ Chest pain | __ Boils | __ Hot flashes |
| __ Arm pain | __ Swollen ankles | __ Sensitive skin | __ Cramps |
| __ Arm numbness | __ Poor circulation | __ Hives | __ Vaginal discharge |
| __ Leg pain | __ Varicose veins | __ Eczema | __ Currently pregnant |
| __ Leg numbness | __ Stroke | | __ Breast implants |
| __ Swollen joints | __ Heart attack | | Date of last PAP! ______ |
| __ Painful tailbone | | | |
| __ Foot pain | | | |
| __ Spinal curvature | | | |

Have you had any of the following surgeries? If yes, please list date.

| | | | | | |
|---|---|---|---|---|---|
| __ Tonsillectomy | ______ | __ Gall bladder | ______ | __ Hernia | ______ |
| __ Tubes in ears | ______ | __ Stomach | ______ | __ Cataract | ______ |
| __ Sinus | ______ | __ Appendectomy | ______ | __ Vision correction | ______ |
| __ Thyroid | ______ | __ Female organs | ______ | __ Breast reduction | ______ |
| __ TMJ | ______ | __ Hemorrhoids | ______ | __ Mastectomy | ______ |
| __ Neck | ______ | __ Back | ______ | __ Prostate | ______ |

List any accidents, injuries, falls and dates.

__ Car: ______________________________

__ Sports: ______________________________

__ School: ______________________________

__ Other: ______________________________