

CASE HISTORY

Name: _____ Age _____ Date: _____ Case Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (Home): _____ 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: _____
 Chief Complaint: 1 - _____ Duration-(How Long): _____ Previous Episodes: _____
 List Current: 2. _____ Duration-(How Long): _____ Previous Episodes: _____
 Problems: 1 _____ Duration-(How Long): _____ Previous Episodes: _____

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: _____

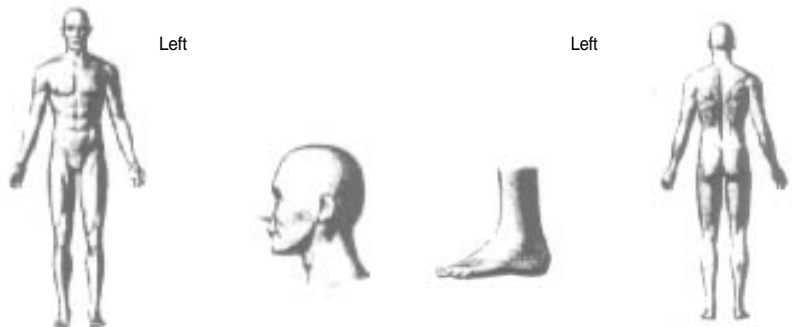
Please mark the intensity of your pain today.

1 - NO PAIN
 10 - MOST INTENSE EVER FELT
 Example _____ Neck _____

DOCTORS USE ONLY

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

- N-Numbness
 T-Tingling
 S-Soreness
 P-Pain
 A-Ache
 ST-Stiffness



HABIT
 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 _____
 Father _____
 Brother, # of _____ _____
 Sister, # of _____ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> 541 Appendicitis | <input type="checkbox"/> 280 Anemi | <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 Pleuris | <input type="checkbox"/> 724.2 Lumbago |
| <input type="checkbox"/> Oil 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 Asthm | <input type="checkbox"/> 346.9 Migraine Headaches | <input type="checkbox"/> 054.9 Herpe | <input type="checkbox"/> 340 Multiple Sclerosis |

