CELL PHONE #_____

CASE HISTORY

Name _____ MI. 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) _____

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 # _____ Driver's License # _____

Spouse's Insurance Co. _____ Telephone _____

Spouse's Social Security # _____ Spouse's Driver's License # _____

Chief Complaint 1. _____

(List Current Problems) 2. _____

3. _____

PRIVACY NOTICE - DUE TO AN OPEN THERAPY AREA - PRIVACY AREA AVAILABLE UPON REQUEST

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the job ❑ Auto Accident ❑ Personal Injury ❑ Other

Have you made a report of your accident? ❑ No ❑ Yes ❑ To employer ❑ Auto Carrier ❑ Other _____

Has the accident been reported? ❑ No ❑ Yes ❑ Workers' Comp. ❑ 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 GIVE MOST CURRENT DATE

Spinal Exam _____

Disc. Exam _____

X-ray Exam _____

Lab Exam _____

Last Physical _____

FEMALE ONLY

Pap smear _____

Breast exam _____

DOCTORS USE ONLY

_____

_____

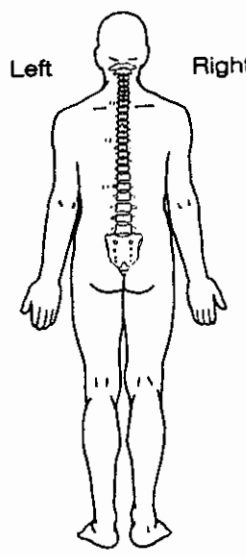
_____

_____

_____

SEVERITY OF PAIN

List region of pain and circle severity number. [1 = least, 10 = greatest]



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

MARK PAIN AREA

+++ Burning
000 Stabbing
--- Sharp
||| Constant

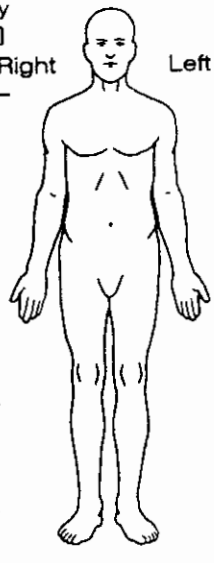
1. _____ 1 2 3 4 5 6 7 8 9 10

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 area of pain on the drawing using the code listed above.

HABITS

❑ Smoking Packs/Day _____

❑ Drinking Alcohol _____

❑ Coffee Cups/Day _____

EXERCISE

❑ None

❑ Moderate

❑ Daily

Type _____

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

❑ 716 Arthritis
❑ 345 Epilepsy
❑ 319 Mental Disorder
❑ 724.2 Lumbago
❑ 690 Eczema