# CASE HISTORY

(2)

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) _____

Insured's Name _____ 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# _____ Driver's License# _____

Spouse's Insurance Company _____ Telephone _____

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

Chief Complaint / List Current Problems

1. _____ Duration-(How Long) _____ Previous Episodes _____
2. _____ Duration-(How Long) _____ Previous Episodes _____
3. _____ 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 _____

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

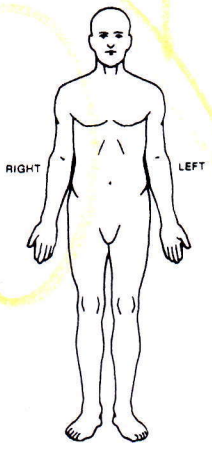
3. _____
1 2 3 4 5 6 7 8 9 10

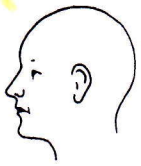
**DOCTORS USE ONLY**

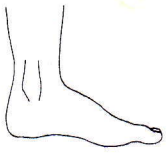
_____
_____
_____
_____
_____

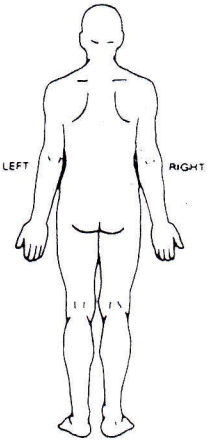
**Please mark area & type of pain on the drawings using the code listed below.**

N — Numbness
T — Tingling
S — Soreness
P — Pain
A — Ache
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, 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 Infection
❑ 716 Arthritis
❑ 345 Epilepsy
❑ 319 Mental Disorder
❑ 724.2 Lumbago
❑ 690 Eczema
❑ 044 HIV Positive

(OVER)