CONFIDENTIAL CASE HISTORY

Name _____Date of Birth _____Age _____Date _____
Address _____ City _____ State_____ Zip_____
Phone (H) _____Phone (Cell) _____ Email _____
Sex: M/F Marital Status: S/M/D/W Ages of Children _____ Social Security # _____
Occupation & Employer _____ Phone (Work)_____
Spouse's Name _____Spouse's Employer _____ Phone _____
Emergency Contact: Name_____ Phone _____
How were you referred to our office? _____

HEALTH REPORT:
Primary reason for seeking care: _____
Secondary reason for seeking care: _____
List other doctors/practitioners seen for this: _____
List diagnosis and type of treatment: _____
Other things you have tried: _____
Is present condition due to an injury? Yes/No: On the Job __ Auto Accident __ Other _____
Has the accident been reported? Yes/No: To Employer __ Auto Carrier __ Other _____
Have you had similar accidents or injuries before? Yes/No If yes, explain: _____
Have you received chiropractic treatment previously? Where/When: _____
Do you have any relatives who had or have a similar problem? _____
Have you been treated for any other health condition in the last year? Yes/No If yes, explain: _____
_____
Medication _____Dosage _____Frequency _____Condition_____
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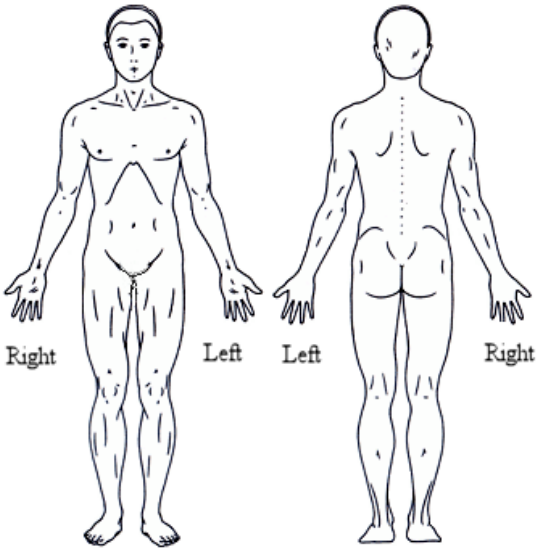
Have you taken other medications in the past? If yes, list:_____
Date of last: X-ray_____ MRI/CT_____ Blood/Urine test_____ Other_____
Surgery_____Date_____Condition_____
Surgery_____Date_____Condition_____
Vitamins/Supplements: _____ _____ _____ _____ _____



Please circle the **LEAST** to **MOST** levels of your usual daily experience of pain or discomfort below:
(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)
Using the symbols below, mark on the pictures where you feel pain or discomfort:

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

What aggravates your condition/pain? _____
What lessens your condition/pain? _____
Is this condition worse certain times of the day? Y/N: _____
Is this condition interfering with Home?_____ Work?_____
Sleep?_____ Recreation?_____ Other?_____
Is this condition progressively getting worse? _____

FAMILY HISTORY: Health conditions, cause and age at death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____

-OVER-

PERSONAL HABITS:
Do you smoke Y/N: #/day__ Alcohol Y/N: Daily __Weekly __Social Occasions__ Caffeinated drinks/day___
Hours of sleep per night: _____ Sleep Quality Scale: (None/Poor Sleep) 0 1 2 3 4 5 6 7 8 9 10 (Rested)
Hours of the day you spend: Sitting_____ Standing_____ Light Labor_____ Heavy Labor_____
Days a week you exercise 20-30 minutes or more:___ Exercise Intensity: (Low) 0 1 2 3 4 5 6 7 8 9 10 (High)
Types of exercise: _____
Physical stress level: 0 1 2 3 4 5 6 7 8 9 10 (High). Emotional stress level: 0 1 2 3 4 5 6 7 8 9 10 (High)
List your major stressors: _____
What are you health goals? _____

Please mark each item below for each condition you have NOW (X) or had in the PAST (P):

GENERAL SYMPTOMS
__ Anxiety/Nervousness
__ Dizziness/Vertigo
__ Tired/Fatigue
__ Anemia
__ Headache/Migranes
__ Insomnia
__ Forgetful/Memory loss
__ Cancer:_____
Date(s)_____

MUSCLES & JOINTS
__ Neck Problems
__ Arm Pain/Numbness R/L
__ Pain between Shoulders
__ Lower Back Problems
__ Knee Pain/Stiffness R/L
__ Leg Pain/Numbness R/L
__ Swollen Joints
__ Painful/Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones_____

CARDIO-VASCULAR
__ High/Low Blood Pressure
__ Heart Pain/Angina
__ Heart Attack
__ Heart Issues:_____
__ Rapid Heart
__ Slow Heart
__ Poor Circulation
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises (tinnitus)
__ Frequent Colds
__ Hay Fever
__ Nasal Stuffiness
__ Sinusitis
__ Nose Bleeds
__ Sore Throats
__ Tonsillitis
__ Eye Floaters
__ Poor Vision

ENDOCRINE
__ Hypo/Hyper Thyroid
__ Hypo/Hyper Adrenal
__ Hypo/Hyper Glycemia
__ Diabetes

GASTRO-INTESTINAL
__ Belching/Gas
__ Heartburn/GERD
__ Ulcer
__ Constipation
__ Diarrhea
__ Excessive Hunger/Thirst
__ Poor Appetite
__ Poor Digestion
__ Gall Bladder Pain/Stones
__ Liver Problems
__ Abdominal Pain
__ Nausea
__ Vomiting
__ Bowel Problems
__ Hemorrhoids
__ Black/Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Painful Urination
__ Kidney Infection/Stones
__ Loss of Bladder Control
__ Prostate Problems

SKIN OR ALLERGIES
__ Acne
__ Allergies: _____
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin

FOR WOMEN ONLY
__ Birth Control type _____
__ Breast Pain
__ Cramps/Backaches
__ Excessive Flow
__ Painful Periods
__ Irregular Cycle
__ Hysterectomy/Ovariotomy
__ Miscarriage
__ Pre/Post menopausal
__ Hot Flashes/Night Sweats
__ Hormone Replacement
Pregnant at this Time? Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____
Representative Signature (if minor) _____ Date_____