PERSONAL CASE HISTORY

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Ph# (H) _____ (C) _____ (W) _____ DOB _____ Age _____

Referred by _____ Social Sec# _____

Occupation _____ Employer _____ Marital Status: S M D W

Spouses Name _____ Spouses Occupation _____

Type of health Ins. _____ Birth Date of Primary Insured _____

# of Children ____ Ages _____ Emergency Contact _____ Ph # _____

email address: _____

CURRENT HEALTH CONDITION

Purpose of This Appt. _____

Other Doctors Seen for This Condition _____

When Did This Condition Begin? _____

If Disabled From Work, Please Give Dates _____

☐ Job related ☐ Auto Related ☐ Other

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers

☐ Blood Pressure Med. ☐ Insulin Other _____

Have you had any long term steroid therapy? No Yes Explain _____

Previous Chiropractic Care

Dr.'s Name/Approx. Date of Last Visit _____

Current Health Habits

Yes	NO	
☐	☐	Did you or do you smoke? _____
☐	☐	Did or do you drink any alcohol? _____
☐	☐	Diet (Do you eat healthy foods?) _____
☐	☐	Do you exercise regularly? _____
☐	☐	Sleeping Habits (Nightmares?) _____
☐	☐	Did you or do you have occupational stress? _____
☐	☐	Physical stress? _____
☐	☐	Mental stress? _____
☐	☐	Hobbies/Sports injuries? _____
☐	☐	Sleeping Posture ☐Side ☐Stomach ☐Back _____

PAST HEALTH HISTORY

Major Surgery/Operations: _____

_____

Major Accidents/Falls: _____

Hospitalization (other than above) _____

Have you been treated for any health condition in the past year ? ☐ Yes ☐ No

If yes, please explain: _____

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Stroke
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Asthma
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema
- ☐ HIV / AIDS

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain-Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing / Clicking Jaw

GENERAL CODE

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

FEMALES ONLY:
When was your last period?
_____
Are you Pregnant? Y N Maybe
(circle one)

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/ Depression
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Fainting

GASTRO-INTESTINAL CODE

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas / Bloating after meals
- ☐ Heartburn
- ☐ Black / Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

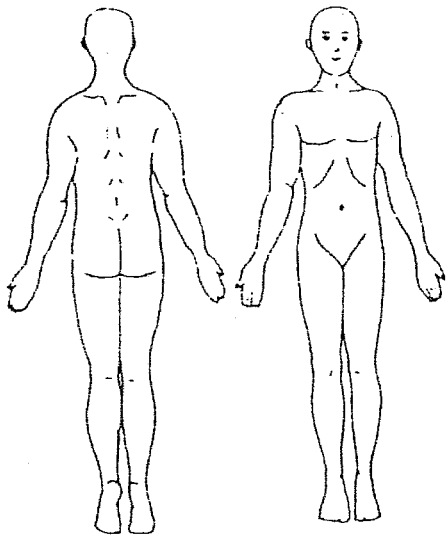
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT CODE

- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Vision Problems

MALE/ FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain /Infection
- ☐ Breast Pains /Lumps
- ☐ Prostate /Sexual Dysfunction
- ☐ Genital Herpes



WHY CHIROPRACTIC? People go to Chiropractors for a variety of reasons:
RELIEF CARE: Some go for symptomatic relief of pain or discomfort.
CORRECTIVE CARE: Some are interested in having the cause of the problem as well as the symptoms corrected and relieved.
COMPREHENSIVE CARE: Others want whatever is still malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care.
Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so the we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care

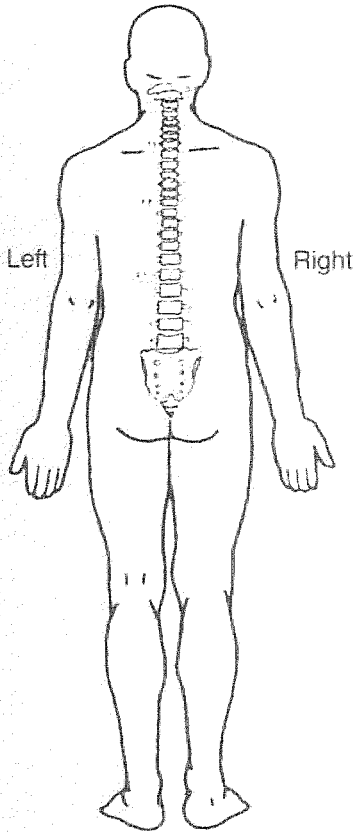
☐Check here if you want the Doctor to select the type of care appropriate for your condition.

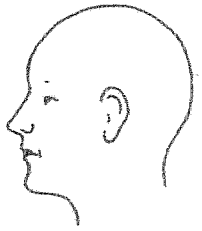
Patient's or Guardian's Signature _____ Date_____

PATIENT CONSULTATION

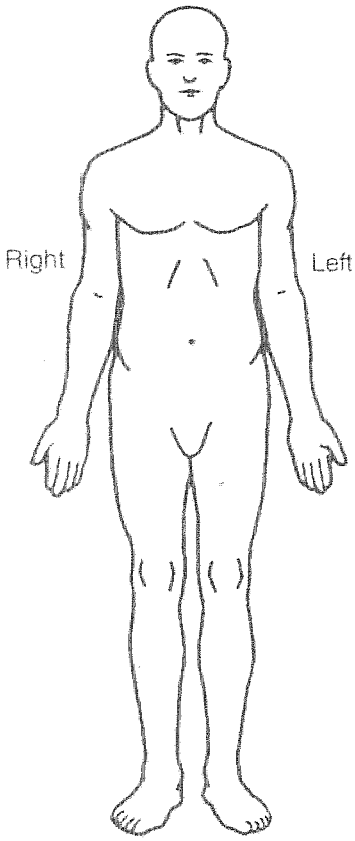
TAKEN BY: _____

Name _____ Date _____ D I S C





	Overall Severity
	Mild
	Mild To Moderate
	Moderate
	Severe
	Moderately Severe
	Very Severe



List Of Major Complaints

	Pain Scale
1 _____	1 - 10
2 _____	1 - 10
3 _____	1 - 10
4 _____	1 - 10
5 _____	1 - 10

1. When was the 1st time you ever had (Back) trouble _____ what happened _____
2. Date when this condition started _____ / _____
3. If known, state cause of current pain _____
4. Is this condition ☐ Getting worse ☐ Getting better ☐ Staying the same
5. Are there any movements or positions that aggravate this condition _____
6. What is the worst time of your day ☐ Morning ☐ Afternoon ☐ Evening
7. Describe your pain ☐ Dull ache ☐ Sharp pain ☐ Burning Numbness
8. Is your pain ☐ Constant ☐ Intermittent ☐ Frequent ☐ Occasional Does anything relieve your pain _____
9. Have you ever been treated for present condition ☐ No ☐ Yes When _____ Who treated you _____
10. Treatment received _____ Reason for changing care _____
11. Have you had a similar condition ☐ No ☐ Yes When _____ Were you treated _____ By who _____
12. Treatment received _____ Are you off work ☐ Yes ☐ No Date last worked _____
13. Any previous accidents _____
14. Any previous falls _____
15. Any previous surgeries _____ Previous broken bones _____
16. Any other illnesses or health problems _____
17. Family history of Heart Disease? _____ Diabetes? _____ Cancer? _____
18. Gained or lost more than 10 lbs. in last 6 mos. _____ Any chance you are pregnant _____

Diagnosis _____