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CASE HISTORY

Name:____________ Case Number____________ Date:____________
Address (City, State, Zip)____________ Phone (Home)____________
Date of Birth________ Age_____ Sex:__M __F Marital Status: S M D W Number of Children________
Occupation:____________ Employer:____________ Phone (Work)____________
Spouses Name:____________ Spouses Occupation:____________
Spouses Employer:____________ Phone (work)____________
Referred by:____________ Past Chiropractic Care: __Y __N When:____________
Chief Complaint (Areas of Pain)____________

Rate degree of pain: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

Insurance Company:____________ **S.S.#**____________ Drivers License #____________
Spouses Insurance Company:____________ Spouses S.S.#____________ Spouses Driv. Lic #____________

Are your present injuries due to on the job injury? __Yes __No Spinal Exam____________
Have you made a report of your accident to your employer? __Yes __No Disc Exam____________
Do you plan on turning it in on Workmen's Comp.? __Yes __No Lab____________
Are you now or have you ever been disabled? __Yes __No Last Physical____________

If yes, When____________ How____________

Please make a check by the signs or symptoms that you have or had in the past

GENERAL SYMPTOMS
___Headache
___Night Sweats
___Fainting
___Convulsions
___Loss of Sleep
___Fatigue
___Numbness in arms
___Numbness in legs
___Numbness in hands
___Numbness in feet
___Pain in arms
___Pain in hands
___Pain in legs
___Pain in feet

GASTRO-INTESTINAL
___Nausea
___Vomiting
___Vomiting Blood
___Pain over Stomach
___Constipation
___Diarrhea
___Liver Trouble
___Jaundice
___Gall Bladder Trouble
___Hernia

RESPIRATORY
___Chronic Cough
___Spit Blood
___Spit Phelgm
___Chest Pain
___Trouble Breathing

GENITO-URINARY
___Frequent Urination
___Painful Urination
___Blood in Urine
___Kidney infection
___Bed wetting
___Inability to control urine
___Prostate Trouble

HABITS
___Smoking/pks day__
___Drinking __Alcohol__
___Coffee__Cups/day

EXERCISE
1. ___None
2. ___Moderate 1x/week
3. ___3x/week
4. ___Daily

MUSCLE & JOINTS
___Stiff Neck
___Mid-back pain
___Low back pain
___Backache
___Painful Tail bone
___Spinal Curvature
___Swollen Joints
___Tremors
___Weakness
___Twitching

CARDIO-VASCULAR
___Rapid Heart
___Slow Heart
___High Blood Pressure
___Low Blood Pressure
___Pain over Heart
___Prev. Heart Trouble
___Swelling of Ankles
___Poor Circulation
___Varicose Veins
___Strokes

FOR WOMEN ONLY
___Painful Periods
___Excessive Flow
___Irregular Cycles
___Hot Flashes
___Cramps or Backache
___Miscarriage
___Vaginal Discharge
___Pregnant at this time
___Last Pap
___By Whom:__________

NERVOUS SYSTEM
___Neuralgia-shooting pains
___Paresthesia "tingling"
___Vertigo-loss of balance
___Loss of Sensations
___Loss of Cordination
___Loss of consciousness