

CASE HISTORY

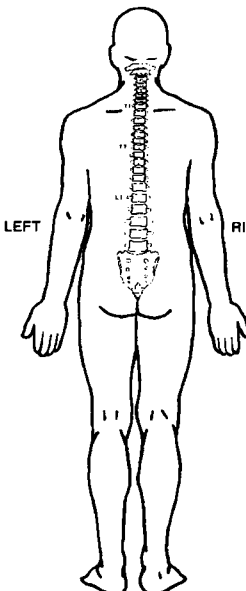
Date _____ Case Number _____
 Name _____ Phone (Home) _____ Date of Birth _____
 Address _____ Age _____ Sex: M F
 Marital Status: S M D W
 Occupation _____ Employer _____ Telephone (Work) _____
 Spouse's Name _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Telephone (Work) _____
 Referred By _____ Past Chiropractic Care Yes No When _____
 Doctor's Name _____ Results _____
 Chief Complaint 1. _____
 2. _____
 3. _____
 Insurance Company _____ Telephone _____
 Social Security # _____ Driver's License # _____
 Spouse's Insurance Co. _____ Telephone _____
 Spouse's Social Security # _____ Spouse's Driver's License # _____

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 _____

DOCTOR'S USE ONLY

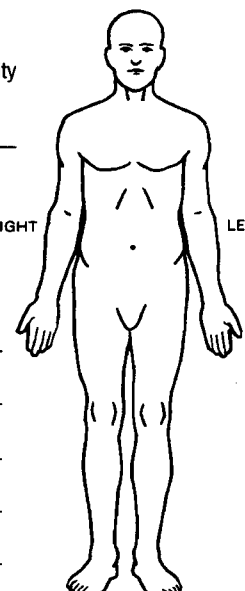


LEFT RIGHT

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. _____
 2. _____
 3. _____
 4. _____
 5. _____



RIGHT LEFT

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--------------------------|--------------------------|--------------------------|---------------|---------------|-------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <p>HABITS</p> <p><input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Drinking Alcohol _____ <input type="checkbox"/> Coffee Cups/Day _____</p> | <p>EXERCISE</p> <p><input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily</p> | <p>FAMILY HISTORY</p> <table border="0" style="width: 100%;"> <tr> <td></td> <td>Diabetes</td> <td>Heart</td> <td>Kidney</td> <td>Cancer</td> <td>Back</td> </tr> <tr> <td>Mother</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Father</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Brother, No. of _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sister, No. of _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> | | Diabetes | Heart | Kidney | Cancer | Back | Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brother, No. of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sister, No. of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

| | | | |
|---------------------------|-------------------------|--------------------------------|-----------------------------|
| _____ 541 Appendicitis | _____ 285.9 Anemia | _____ 429.9 Heart Disease | _____ 716.9 Arthritis |
| _____ 541 Pneumonia | _____ 285.9 Measles | _____ 429.9 Goiter | _____ 716.9 Epilepsy |
| _____ 541 Rheumatic Fever | _____ 285.9 Mumps | _____ 429.9 Influenza | _____ 716.9 Mental Disorder |
| _____ 541 Polio | _____ 285.9 Chicken Pox | _____ 429.9 Pleurisy | _____ 716.9 Lumbago |
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| _____ 541 Whooping Cough | _____ 285.9 Cancer | _____ 429.9 Venereal Infection | _____ AIDS |

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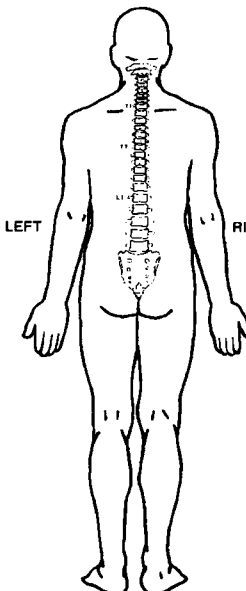
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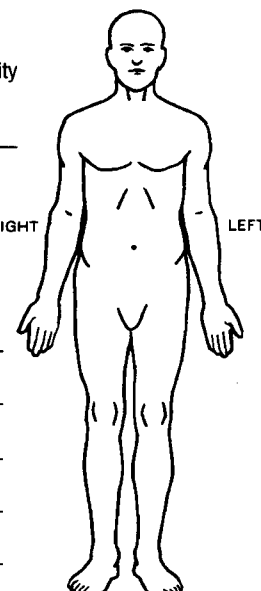
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