CASE NO. ____________

CASE HISTORY
(please print)

LAST NAME ____________ FIRST NAME ____________ MIDDLE ____________

Address ____________ City ____________ State ______ Zip ______

Home phone ( ) ____________ Work phone ( ) ____________

Occupation ____________ Employer ____________

Social Security no. ____________ Drivers license no. ____________

Birth date ____________ Age ______ Sex ______ Marital status ❑ S ❑ M ❑ D ❑ W

Spouses name ____________ No. of children ______ Ages ____________

Contact in case of emergency ____________ Referred by ____________

Email Address ____________

What is your major complaint? ____________

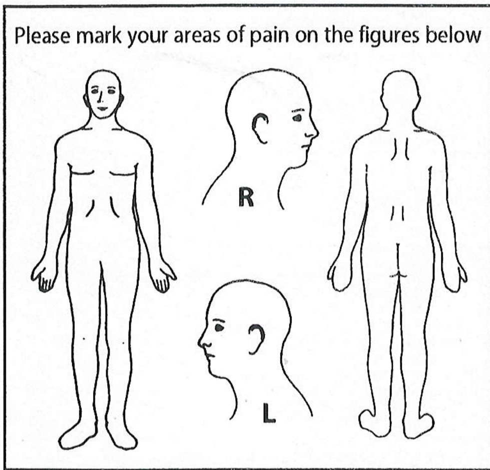
How long have you had this condition? ____________ Have you had this or a similar condition in the past? ____________

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Did your injury occur while at work? ❑ Yes ❑ No When? ____________

Other complaints? ____________

Please mark your areas of pain on the figures below



✓ CHECK THE CONDITIONS THAT AFFECT YOU.

___ Neck problems	___ Broken bones	___ Asthma
___ Shoulder problems	___ Muscle cramps	___ Eczema
___ Arm problems	___ Weak muscles	___ Shingles
___ Numbness - Arms	___ Headaches	___ Nausea
___ Pain between shoulders	___ Dizziness	___ Poor digestion
___ Low back problems	___ Fainting	___ Ulcers
___ Leg problems	___ Forgetfulness	___ Diarrhea
___ Numbness - Legs	___ Depression	___ Constipation
___ Loss of feeling	___ Vision problems	___ Kidney infection
___ Stiff joints	___ Ear pain/noises	___ Menstrual cramps
___ Painful joints	___ Ear Infections	___ Diabetes
___ Restricts daily activity	___ Hearing loss	___ Blood pressure High/Low
___ Restricts regular exercise	___ Frequent colds	___ Tiredness/fatigue
___ Sore muscles	___ Allergies	
___ Walking problems	___ Hay fever	

- This is a ❑ new / ❑ old illness. It ❑ was / ❑ was not treated before.
  If treated before, what was done? ____________
- Name of Doctors ____________
- List surgeries ____________
- Have you ever had Chiropractic care before? ❑ Yes ❑ No
  Name of Doctor ____________ Date ____________
- Last time you had spinal x-rays or other x-rays ____________
- Medications you now take ____________
- Are you pregnant? ❑ Yes ❑ No ❑ N/A

From birth to present, please list by date and describe.

1 Car accidents ____________

2 Falls/Injuries (including sports) ____________

3 Other ____________

Do you have Health Insurance? ❑ Yes ❑ No

Please give card to front desk C.A. for verification.

I clearly understand and agree that all first visit charges are payable when services are rendered.

Patient's Signature ____________ Date ____________

SHARE CHIROPRACTIC WITH YOUR FRIENDS AND FAMILY