

Case History

Name (First & Last): _____ Date: _____
 How did you hear about us? _____ Date of Birth: _____
 Occupation: _____ Employer: _____ Address: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Email: _____
 Emergency Contact Info: Name: _____ Relationship: _____ Phone: _____
 Who is your Medical Doctor? _____ Phone: _____
 Address _____ City: _____ State: _____ Zip: _____
 Do you have medical insurance? Yes No Would you like us to verify your insurance? Yes No
 Name of Insurance Company _____ Phone # _____
 Name of Insured _____ SS# _____ Date of Birth _____
 Insured's Employer _____
 Name of Insurance Company _____ Phone # _____
 Address _____ City _____ State _____ Zip _____
 Group # _____ ID # _____

Which areas carry the most tension? _____
 Have you ever had a professional massage before? YES NO
 Do you wear contact lenses? YES NO
 Do you have any known allergies? (ie. Food, nuts, or oils) _____
 Do you go to a chiropractor regularly? _____
 If so, Who? And How often? _____
 What are your chief complaints? _____
 Are you taking any prescribed or over the counter medication? YES NO
 If YES, please list and for what? _____

Please Mark the Intensity of Your Pain Today.
 1 - NO PAIN
 10 - MOST INTENSE EVER FELT
 Example Neck
 1 2 3 4 5 6 7 8 9 10
 1. _____
 2. _____
 3. _____
DOCTORS USE ONLY

Please mark area & type of pain on the drawings using the code listed below.

N - Numbness
 T - Tingling
 S - Soreness
 P - Pain
 A - Ache
 ST - Stiffness

FAMILY HISTORY

	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"/>

HABITS

Smoking Packs/Day _____
 Drinking Alcohol _____
 Coffee Cups/Day _____

EXERCISE/SPORTS

None
 Moderate
 Daily
 Type: _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Venereal Infection
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Eczema	<input type="checkbox"/> HIV Positive

PLEASE CHECK THE CORRECT BOX FOR EACH ITEM BELOW. CHECK AT LEAST ONE BOX FOR EACH SIGN OR SYMPTOM LISTED.

Never Previously Presently	SKIN OR ALLERGIES	Never Previously Presently	GENITO-URINARY	Never Previously Presently	CARDIO-VASCULAR	Never Previously Presently	FOR WOMEN ONLY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Boils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bed Wetting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cramps or Backaches
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bruising	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood in Urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Excessive Flow
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dryness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pain over Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bladder Control Issues	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hives or Allergy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Previous Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Miscarriage
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Itching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rapid Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful Periods
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sensitive Skin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Prostate Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Slow Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Skin Eruptions			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Strokes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Birth Control Pills
				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Swelling Ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Pregnant at this Time
				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Last Pap (Date) _____
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	By Whom _____

PLEASE CHECK THE CORRECT BOX FOR EACH ITEM BELOW. CHECK AT LEAST ONE BOX FOR EACH SIGN OR SYMPTOM LISTED.

Never Previously Presently	GENERAL SYMPTOMS	Never Previously Presently	EYE /EAR / NOSE/THROAT	Never Previously Presently	GASTRO-INTESTINAL	Never Previously Presently	MUSCLES & JOINTS
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Allergy (What) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Colon Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Backache
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chills	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Foot Trouble
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hernia
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pain between Shoulders
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ear Noises	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful Tail bone
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Enlarged Thyroid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids (Piles)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stiff Neck
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Spinal Curvature
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Liver Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Swollen Joints
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hoarseness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tremors
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pain over Stomach	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Twitching
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weakness
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neuralgia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pain in Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Digestion		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vomiting		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Numbness or pain Arms/legs/hands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinusitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vomiting Blood		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sore Throats				
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tonsillitis				
							RESPIRATORY
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest Pain
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic Cough
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Difficulty Breathing
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Spitting Blood
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Spitting Phlegm

OPERATIONS AND PROCEDURES

DATE _____	Vaccinations	DATE _____	Tubes in Ears	DATE _____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other _____	_____	Other _____	_____	Other _____

I HAVE NEVER HAD ANY OPERATIONS/SURGERIES. **X** _____

List any accidents or falls and dates: Car _____ Recreational Vehicle _____
 Sports _____ School _____ Other _____

List any broken bones (fractures) or dislocations: _____
 Ever on Crutches? NO YES Why? _____

Have you ever had any spinal taps or spinal injections? NO YES

Were you ever knocked unconscious? NO YES Have you ever had a lapse of memory? NO YES

Have you ever had X-rays taken? NO YES When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Client's/Guardian's Signature **X** _____ Date: _____

Print Name: _____