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 injuries 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 ❒ Worker's 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 _____

DOCTORS USE ONLY

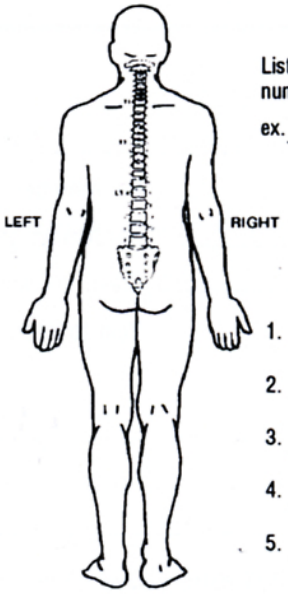
_____

_____

_____

_____

_____



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

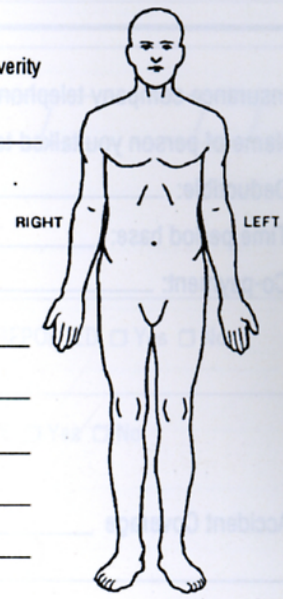
1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10



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

HABITS

❒ Smoking Packs/Day _____

❒ Drinking Alcohol _____

❒ Coffee Cups/Day _____

EXERCISE

❒ None

❒ Moderate

❒ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	❒	❒	❒	❒	❒
Father	❒	❒	❒	❒	❒
Brother, No. of _____	❒	❒	❒	❒	❒
Sister, No. of _____	❒	❒	❒	❒	❒

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
_____541	Tuberculosis	_____285.9	Diabetes	_____429.9	Alcoholism	_____716.9	Eczema
_____541	Whooping Cough	_____285.9	Cancer	_____429.9	Venereal Infection	_____	AIDS

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if never. A complete history and understanding of you health will facilitate care.

GENERAL SYMPTOMS

_____784.0 Headache
_____780.6 Fever
_____780.9 Chills
_____780.8 Night Sweats
_____780.2 Fainting
_____780.4 Dizziness
_____780.3 Convulsions
_____780.52 Loss of Sleep
_____780.7 Fatigue
_____799.2 Nervousness
_____783 Loss of Weight
_____782 Numbness or pain in arms/legs/hands
_____995.3 Allergy (What)
_____786.09 Wheezing
_____729.2 Neuralgia

GASTRO-INTESTINAL

_____783 Poor Appetite
_____536.8 Poor Digestion
_____994.2 Excessive Hunger
_____787.3 Belching or Gas
_____787 Nausea
_____787 Vomiting
_____578 Vomiting Blood
_____536.8 Pain over Stomach
_____564 Constipation
_____558.9 Diarrhea
_____789 Colon Trouble
_____455.6 Hemorrhoids (Piles)
_____785.1 Liver Trouble
_____782.4 Jaundice
_____575.9 Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

_____368.9 Poor Vision
_____378.9 Crossed Eyes
_____379.91 Pain in Eyes
_____389.9 Deafness
_____388.70 Earache
_____388.30 Ear Noises
_____388.60 Ear Discharges
_____478.1 Nasal Obstruction
_____784.7 Nose Bleeds
_____462 Sore Throats
_____784.49 Hoarseness
_____477.9 Hay Fever
_____493.9 Asthma
_____460 Frequent Colds
_____240.9 Enlarged Thyroid
_____463 Tonsillitis
_____686.9 Sinus Trouble

RESPIRATORY

_____786.2 Chronic Cough
_____786.3 Spitting Blood
_____933.1 Spitting Phlegm
_____786.50 Chest Pain
_____786.09 Difficulty Breathing

GENITO-URINARY

_____788.3 Frequent Urination
_____788.1 Painful Urination
_____599.7 Blood in Urine
_____592 Kidney Infection
_____788.3 Bed Wetting
_____788.1 Inability to control Urine
_____601.9 Prostate Trouble

MUSCLE & JOINTS

_____ Weakness
_____ Twitching
_____847 Stiff Neck
_____722.10 Backache
_____719 Swollen Joints
_____781 Tremors
_____729.5 Foot Trouble
_____724.79 Painful Tail Bone
_____724.5 Pain Between Shoulders
_____563.3 Hernia
_____737.3 Spinal Curvature

CARDIO-VASCULAR

_____783 Rapid Heart
_____427.89 Slow Heart
_____401.9 High Blood Pressure
_____458.9 Low Blood Pressure
_____786.51 Pain over Heart
_____438 Previous Heart Trouble
_____719.07 Swelling Ankles
_____759.9 Poor Circulation
_____ Varicose Veins
_____436 Strokes

SKIN OR ALLERGIES

_____368.9 Skin Eruptions
_____698.9 Itching
_____278.8 Bruising Easily
_____701.1 Dryness
_____ Boils
_____782 Sensitive Skin
_____708.9 Hives or Allergy
_____692.9 Eczema
_____ Medicines
_____
_____

FOR WOMEN ONLY

_____786.2 Painful Periods
_____626.2 Excessive Flow
_____626.4 Irregular Cycle
_____627.2 Hot Flashes
_____625.3 Cramps or Backaches
_____634.9 Miscarriage
_____623.5 Vaginal Discharge
_____ Pregnant at this Time
_____ Last Pap
By Who _____
Other _____

OPERATIONS AND PROCEDURES

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

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

List any broken bones or dislocations (fractures): _____

Ever on crutches? ❒ No ❒ Yes Why? _____

Have you ever had any spinal taps or spinal injections? ❒ Yes ❒ No

Were you ever knocked unconscious? ❒ Yes ❒ No

Have you ever had a lapse of memory? ❒ Yes ❒ No

Have you ever had x-rays taken? ❒ No ❒ Yes When? _____ By whom? _____

For what ailments were these pictures made? _____

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

_____

Are you presently taking any medication - prescription or patent? ❒ No ❒ Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X _____ **Date** _____

APC-CH-904.2