REQUIRED FOR YOUR CASE HISTORY FILE

NAME ______________________________________ DATE ____________ ____________
First Middle Last PATIENT # (office use)

ADDRESS ______________________________________ EMAIL: ____________
Street Address City State Zip

HOME PHONE ____________ CELL PHONE ____________ WORK PHONE ____________

DATE OF BIRTH ___/___/___ SEX MALE - FEMALE SOCIAL SECURITY # ___-___-___

CIRCLE IF YOU ARE: MARRIED SINGLE WIDOWED DIVORCED SEPARATED STUDENT

OCCUPATION ____________ EMPLOYER ____________

ADDRESS ______________________________________ NUMBER OF CHILDREN ____________
Street Address City State Zip

SPOUSE'S NAME ____________ SPOUSE'S SOCIAL SECURITY # ___-___-___

SPOUSE'S DATE OF BIRTH ___/___/___ SPOUSE'S EMPLOYER ____________

SPOUSE'S EMPLOYER ADDRESS ____________ TELEPHONE (   ) ____________

NEAREST RELATIVE (NOT LIVING WITH YOU) ____________ TELEPHONE (   ) ____________

PHYSICIAN ____________ TELEPHONE (   ) ____________

DENTIST ____________ TELEPHONE (   ) ____________

LANDLORD ____________ TELEPHONE (   ) ____________

CONTACT IN THE CASE OF AN EMERGENCY? ____________ TELEPHONE (   ) ____________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____________

HAVE YOU EVER HAD CHIROPRACTIC CARE? YES NO DATE ____________

LAST PHYSICAL EXAMINATION ____________ HAVE YOU EVER BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? ____________

IF YES, EXPLAIN: ____________

WHAT MEDICATION(S) ARE YOU TAKING? ____________

HAVE YOU EVER HAD: SURGERY FRACTURES CAR ACCIDENTS
FALLS ON-THE-JOB INJURY

DESCRIBE/DATES ____________

FAMILY HISTORY OF: HEART DISEASE CANCER DIABETES ARTHRITIS
BACK PROBLEMS NECK PROBLEMS DISC PROBLEMS

OTHER ____________

PREVIOUS SERIOUS ILLNESS? ____________

CHECK SYMPTOMS YOU HAVE NOTICED: PATIENT NAME & #: ______

- ☐ HEADACHES
- ☐ NECK PAIN
- ☐ BACK PAIN
- ☐ NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ CHEST PAIN
- ☐ DIZZINESS
- ☐ HEAD SEEMS TOO HEAVY
- ☐ NECK STIFF
- ☐ LEG PAIN
- ☐ ARM PAIN
- ☐ PINS & NEEDLES IN ARMS
- ☐ PINS & NEEDLES IN LEGS
- ☐ NUMBNESS IN FINGERS
- ☐ NUMBNESS IN TOES
- ☐ SHORTNESS OF BREATH
- ☐ LIGHTS BOTHER EYES
- ☐ BUZZING IN EARS
- ☐ EARS RING
- ☐ FACE FLUSHED
- ☐ LOSS OF BALANCE
- ☐ FAINTING
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ DIARRHEA
- ☐ FEET COLD
- ☐ HANDS COLD
- ☐ STOMACH UPSET
- ☐ CONSTIPATION
- ☐ COLD SWEATS
- ☐ FEVER
- ☐ DEPRESSION

MAJOR SYMPTOM ______

SYMPTOMS OTHER THAN ABOVE ______

DATE SYMPTOMS FIRST BEGAN (OR DATE OF ACCIDENT) ______

PAINS ARE (CIRCLE ALL THAT APPLY): SHARP DULL CONSTANT INTERMITTENT

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? ______

WHAT IMPROVES YOUR CONDITION? ______

IS YOUR CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? ______

IS THIS CONDITION INTERFERRING WITH (CIRCLE ALL THAT APPLY): WORK SLEEP ROUTINE

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ______

OTHER DOCTORS SEEN FOR THIS CONDITION ______

ANY HOME REMEDIES? ______

PAST HISTORY

DIZZINESS	YES	NO	NEURITIS	YES	NO
BACKACHES	YES	NO	DIGESTIVE DISORDERS	YES	NO
HEART TROUBLE	YES	NO	NERVOUSNESS	YES	NO
DIABETES	YES	NO	SINUS TROUBLE	YES	NO
TUBERCULOSIS	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	ANEMIA	YES	NO
HEADACHES	YES	NO	CANCER	YES	NO
NUMBNESS	YES	NO	KIDNEY TROUBLE	YES	NO
LUNG PROBLEMS	YES	NO	HOSPITALIZATION	YES	NO

IF YES, EXPLAIN ______

______

REMARKS AND ADDITIONAL INFORMATION ______

______

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), <u>I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED</u>. I HAVE READ, UNDERSTOOD AND COMPLETED ALL THE INFORMATION ON BOTH SIDES OF THIS FORM. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY FUTURE CHANGES IN MY STATUS OR CHANGES APPLICABLE TO THE INFORMATION PROVIDED ON THIS FORM.

SIGNATURE ______ DATE ______