CASE NO. _____

Please fill out the following form in as much detail as possible.

Please Print Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

E-mail Address _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) ___ (F) ___

Weight _____ Referred by _____

Employer _____ Address _____

Married _____ S _____ W _____ D _____ Children _____ Name of Spouse _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes ___ No___ N/A _____

Major complaints and symptoms – please be as specific as you can. Ask the doctor or nurse to help if you need assistance in filling out this section. _____

_____

_____

How do you believe your problem (pain) began? _____

_____

_____

_____

_____

When did you first notice this problem / pain? _____

Have you lost any work? _____ Day and date you last worked _____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you been treated by a Medical Physician for this ailment? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes___No___

Will this case be covered by any insurance company? Major Medical ___ Auto ___ Blue Cross/Blue Shield___ Workers' Compensation ___ Medicare ___ Other ___

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? _____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication (aspirin included)? Yes___No___

If yes, name them _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____
_____ Year _____
_____ Year _____

Have you had any cosmetic surgery, breast implants, etc.? _____ Year _____

Have you had any surgery to replace hip, knee, etc? _____ Year _____

Give dates you have had any of the following (if exact date is unknown, give approximate date)

Blood tests _____ Urinalysis _____

MRI _____ CT Scan _____ Ultrasound _____

Radiation treatment _____ X-Ray examination _____

Other special treatment _____

At what hospital or office were these tests taken? _____

Name of doctor who ordered tests _____

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? Yes___ No___

Do you have any health problems not listed above? _____

Do you faint easily? _____

Do you take vitamins? Yes___ No___If yes, please list them _____

_____

Do you exercise regularly? Yes___ No___What kind of exercise? _____

_____

Habits: (please check)

Cigarettes _____ Quantity _____ Coffee _____ Quantity _____
Alcohol _____ Quantity _____ Tea _____ Quantity _____

Hobbies _____

Have you been treated for any health condition by a physician in the past year? _____

If Yes, what condition? _____

Have you lost or gained weight in the past year? _____

Use this space for any additional information you may wish to discuss _____

_____

_____

Have you had or do you now have any of the following symptoms which are or have been significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had this conditions in the past.

	Now N	**Past P**		**Now N**	**Past P**
Headaches	____	____	FrequencyLoss of Balance	____	____
Neck Pain	____	____	Fainting	____	____
Stiff Neck	____	____	Loss of Smell	____	____
Sleeping	____	____	ProblemsLoss of Taste	____	____
Back	____	____	PainDiarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Frequent Colds	____	____
Shoulder/Neck/Arm Pain	____	____	Stomach Upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in	____	____	FingersFever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
High Blood Pressure	____	____	Diabetes	____	____
Difficulty Urinating	____	____	Hemorrhoids	____	____
Allergies	____	____	Leg Cramps	____	____
Weakness in Arms	____	____	Colitis	____	____
Weakness in legs	____	____	Gall Bladder	____	____
Shortness of Breath	____	____	Indigestion	____	____
Fatigue	____	____	Belching	____	____
Depression	____	____	Vomiting	____	____
Lights Bother Eyes	____	____	Shoulder Pain	____	____
Loss of Memory	____	____	Swelling Joints	____	____
Ears Ring	____	____	Knee Pain	____	____
Face Flushed	____	____	Hayfever	____	____
Buzzing in Ears	____	____	Menstrual Difficulties	____	____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and 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.

PATIENT SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE _____

PATIENT NAME _____ Case No. _____

DATE OF BIRTH _____

DATE _____ INTERVIEWER _____

Do you have chest pain?	Yes___ No___
Do you have any change in bowel or bladder habits?	Yes___ No___
Do you have a sore that does not heal?	Yes___ No___
Do you have any unusual bleeding or discharge?	Yes___ No___
Do you have any thickening in your breasts or elsewhere?	Yes___ No___
Do you have indigestion or difficulty in swallowing?	Yes___ No___
Do you have a change in any wart or mole?	Yes___ No___
Do you have a nagging cough or hoarseness?	Yes___ No___
Do you have headaches for hours or days?	Yes___ No___
Do you have blurred vision?	Yes___ No___
Do you have night sweats?	Yes___ No___
Do you have pain in neck, jaw or face?	Yes___ No___
Do you have a drooping eyelid or any change in your pupils?	Yes___ No___
Do you have vertigo (dizziness)?	Yes___ No___
Do you have double vision?	Yes___ No___
Do you have any visual disturbances?	Yes___ No___
Do you have any nausea or vomiting?	Yes___ No___
Do you have any slurred speech?	Yes___ No___
Do you have any ringing in your ears?	Yes___ No___
Do you pass out easily (faint)?	Yes ___ No___
Do you take birth control pills?	Yes___ No___
Do you have a history of stroke in your family?	Yes___ No___

What prescription medication are you taking if any?

[ ] High blood pressure medication
[ ] Blood thinners
[ ] Other _____

[ ] List allergies or adverse reactions to medications _____

_____

Have you ever had cancer? Yes___ No___

Does your pain ever wake you from a sound sleep? Yes___ No___

Are you losing weight now without trying? Yes___ No___

Are you coughing up blood or noticing it in your stools or urine? Yes___ No___

Have you had any loss of bladder or bowel control? Yes___ No___

Have you lost consciousness or had double vision recently? Yes___ No___

Are you seeing any other doctor now for any reason? Yes___ No___

Note: _____

Are you taking any medications or over-the-counter drugs? Yes___ No___

Please indicate type (aspirin, etc.) _____

What was the date of onset of your last menses? _____

SOCIAL HISTORY

Smoker _____ Yes or_____ No, If Yes, How many packs _____
Alcohol _____ Yes or_____ No, If Yes, How much _____

FAMILY HISTORY
Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both

( )High Blood Pressure
( )Heart Attack
( )Emphysema
( )Seizures-Convulsions
( )HIV Positive
( )Asthma
( )Diabetes
( )Kidney Disease
( )Pacemaker
( )Ulcer or Stomach Problems
( )Stroke
( )Arthritis-Rheumatism
( )Mental Illness
( )Thyroid Disease
( )Circulation Problems
( )Cancer
( )Osteoporosis

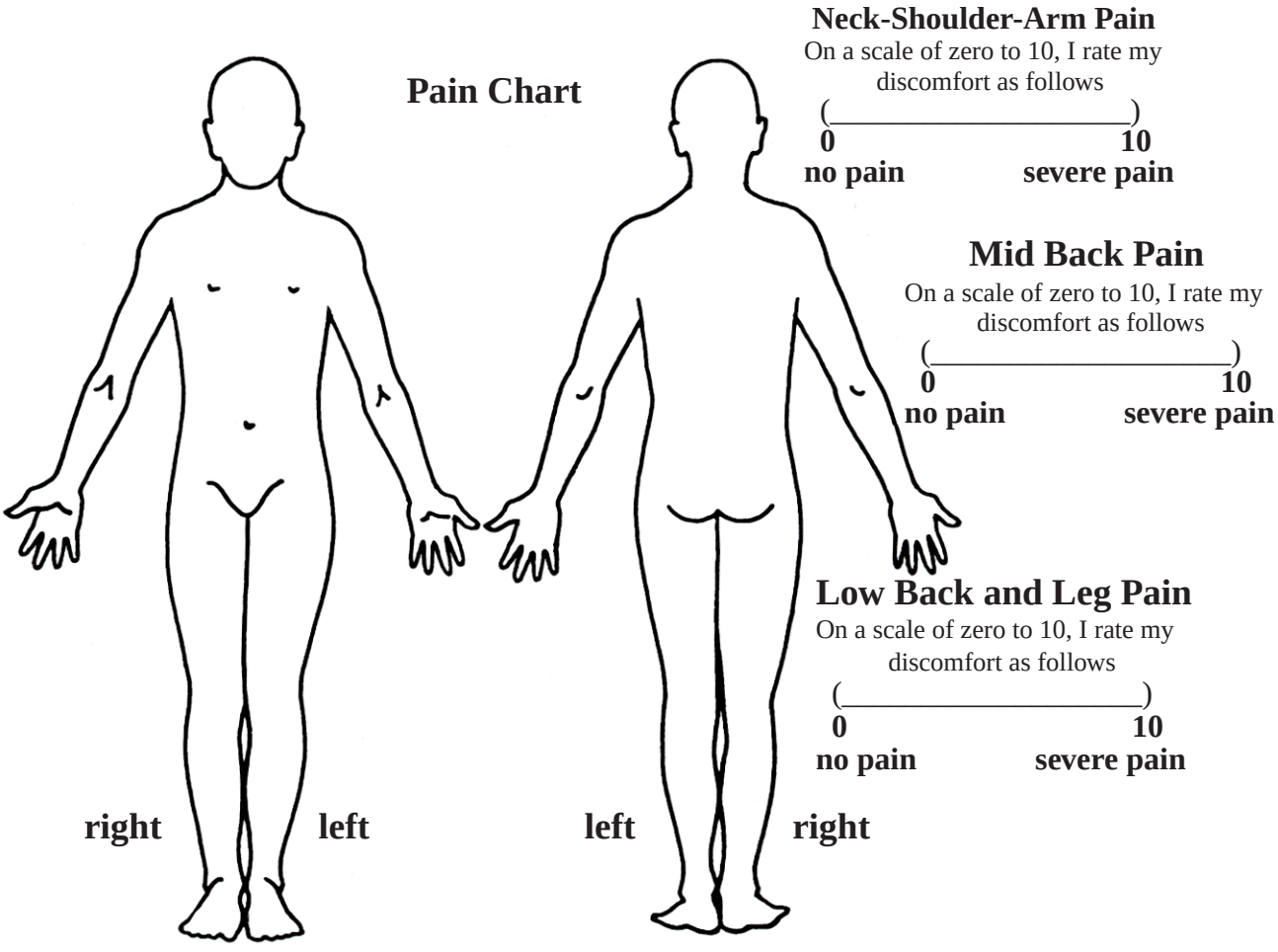
Comments: _____
_____
_____
_____
_____
_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Date: _____ Signature _____