CASE HISTORY

Date:____________________________Case Number: __________________________Email: ___________________
Name: ____Address (City, State, Zip): ____________________________
Phone (Home): ____________Date of Birth: _______Age: __Sex: M F Marital Status: S M D W
Occupation: ________Employer: __________Phone(Work): ______Spouses Name: _____ No. Children: ___
Spouses Occupation: _____________Spouses Employer: ______________Spouses Date of Birth: ___________
Referred By: _____________________Past Chiropractic Care: Yes No When: _______________________
Doctor's Last name: _________________________________Results: ______________________________________
Chief Complaint: ____
Insurance Company: ___________________S.S. No.: _________________Drivers License No.: _____________
Spouses Insurance Company: ___________Spouses S.S.: _____________Spouses Drivers License: _________
Are your present injuries due to on-the-job injury? Yes No Spinal Ex _________________
Have you made a report of your accident to your employer? Yes No Disc Ex ___________________
Do you plan on turning it in on workman's compensation? Yes No Lab Ex ____________________
Are you now or have you ever been disabled (service or work)? Yes No Last Physical _____________
If yes, When __________________________________ How ____

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 Hunter
____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 Hemmorrhoids (Piles)
____785.1 Liver Trouble
____782.4 Jaundice
____575.9 Gall Bladder Trouble

EYE EAR NOS 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 Throat
____784.49 Hoarseness
____477.9 Har Fever
____493.9 Asthma
____460 Frequent Colds
____240.9 Enlarged Thyroid
____463 Tonsillitus
____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
____553.9 Hernia
____737.3 Spinal Curvature

VARDIO-VASCULAR

____ Rapid Heart
____ Slow Heart
____ High Blood Pressure
____ Low Blood Pressure
____ Pain Over Heart
____ Prev. Heart Trouble
____ Swelling of Ankles
____ Poor Circulation
____ Caricose Veins
____ Strokes

SKIN OR ALLERGIES

____ Skin Eruptions
____ Itching
____ Bruising Easily
____ Dryness
____ Boils
____ Sensitive Skin
____ Hives or Allergy
____ Eczema
____ Medicines

FOR WOMEN ONLY

____ Painful Periods
____ Excessive Flow
____ Irregular Cycles
____ Hot Flashes
____ Cramps or Backache
____ Miscarriage
____ Vaginal Discharge
____ Pregnant at this time
____ Last Pap
By Who: ________________
Other: ________________
____

HABITS

____ Smoking ____ pks/day ____
____ Drinking ____ Alchohol ____
____ Coffee ___ cups/day ____

EXERCISE

None
Moderate
Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother					
Fater					
Brother No. of _____					
Sister No. of ______					

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____541 Appendicitis
____541 Pneumonia
____541 Rheumatic Fever
____541 Polio
____541 Tuberculosis
____541 Whooping Cough
____285.9 Anemia
____285.9 Measles
____285.9 Mumps
____285.9 Chicken Pox
____285.9 Diabetes
____285.9 Cancer
____429.9 Heart Disease
____429.9 Goiter
____429.9 Influenza
____429.9 Pleurisy
____429.9 Alcoholism
____429.9 Venereal Infection
____716.9 Arthritis
____716.9 Epilepsy
____716.9 Mental Disorder
____716.9 Lumbago
____716.9 Eczema

OPERATIONS & PROCEDURES

Date ______________ Vaccinations | Date ______________ Tubes in Ears | Date ______________ Sinus
Date ______________ Tonsillectomy | Date ______________ Appendectomy | Date ______________ Hernia
Date ______________ Gall Bladder | Date ______________ Female Organs | Date ______________ Thyroid
Date ______________ Back Operations | Date ______________ Rectal Surgery | Date ______________ Stomach

Other ____ (list type and date)

LIST ANY ACCIDENTS OR FALLS: Car ______________________________

Motorcycle ______________________________ Other ______________________________

Sports ______________________________ School ______________________________

BROKEN BONES OR DISLOCATIONS: (Fractures) ______________________________

Ever on Crutches? Yes ________ No ________ 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? ______________________ Have you ever had X-Rays Taken? ___________

If so, When: ______________________________ By Whom? ______________________________

For what ailments were these pictures made? ______________________________

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

____

Are you presently taking any medication – Prescription or patent? ______________________________

If so, what drugs? ______________________________

NOTE: It is understood and agreed the amount paid ______________________ 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 s/he is responsible for payment for all bills incurred at this office. (X-rays are not transferable.)

Signature: ____ Date: _______________

To avoid added bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

Bottom Office Use Only

Spinal Examination and Analysis

N.S.	Palpation	XRay	Re-X-Ray Gon
	Oc	Oc	Oc
	At	At	At
	Ax	Ax	Ax
	3C	3C	3C
	4	4	4
	5	5	5
	6	6	6
	7	7	7
	10	10	10
	2	2	2
	3	3	3
	4	4	4
	5	5	5
	6	6	6
	7	7	7
	8	8	8
	9	9	9
	10	10	10
	11	11	11
	12	12	12
	1L	1L	1L
	2	2	2
	3	3	3
	4	4	4
	5	5	5
	Sec	Sec	Sec
	R 1h	R 1h	R 1h
	L 1h	L 1h	L 1h
	Coc	Coc	Coc

X-Ray Views Abnormalities

____

____

Georges Test ______________________

____

P _______BP _____ HT _____ WT _____

VISUAL POSTURE ANALYSIS A-P

Head Tilt RT LT R. Ear Hi Lo
R. Shoulder Hi Lo Scapula Hi Lo
R. Ilium Hi Lo LAT:
Head Carried ____________________

Cervical Spine __________________ Curve

Dorsal Spine ___________________ Curve

Lumbar Spine __________________ Curve

Areas of Muscle Spasm C _______________

D ___________ L ___________ P___________

Range of Motion

Cervical	L	R	Lum Dor.	L	R
Flx (65)			Flx (95)		
Ext (50)			Ext (35)		
L.F. (40)			L.F. (40)		
Rot (55)			Rot (35)		

Dynagrip R ___________ L ___________

Other ______________________________

____

____

	LEFT	RIGHT
Foramina Compression		
Shoulder Depressor		
Distraction		
Darefield Pelvic		
Darefield Cervical		
Ely's		
Soto Hall		
Laseque		
Braggard		
Fabers		
Leg Raiser		
Lewin's Supine		
Trendelburg		
Adams		
Romberg's		

DOCTORS COMMENTS: ______________________________

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