Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ☐ Never ☐ Previously ☐ Presently

Never	Previously	Presently	GENERAL SYMPTOMS						GASTRO-INTESTINAL						EYE/EAR/NOISE/THROAT						RESPIRATORY					
☐	☐	☐	995.3	Allergy (What)____					☐	☐	☐	787.3	Belching/Gas/Bloating		☐	☐	☐	493.9	Asthma		☐	☐	☐	786.50	Chest Pain	
			_____						☐	☐	☐	789.0	Abdominal Pain		☐	☐	☐	378.9	Crossed Eyes		☐	☐	☐	786.2	Chronic Cough	
☐	☐	☐	490	Bronchitis					☐	☐	☐	564.0	Constipation		☐	☐	☐	389.9	Deafness		☐	☐	☐	786.09	Difficulty Breathi	
☐	☐	☐	780.9	Chills					☐	☐	☐	787.91	Diarrhea		☐	☐	☐	388.70	Earache		☐	☐	☐	786.3	Spitting Blood	
☐	☐	☐	780.39	Convulsions					☐	☐	☐	783.6	Excessive Eating		☐	☐	☐	388.60	Ear Discharge		☐	☐	☐	786.4	Spitting Phlegm	
☐	☐	☐	780.4	Dizziness					☐	☐	☐	575.9	Gall Bladder Trouble		☐	☐	☐	388.30	Ear Noises							
☐	☐	☐	780.2	Fainting					☐	☐	☐	455	Hemorrhoids (piles)		☐	☐	☐	240.9	Enlarged Thyroid							
☐	☐	☐	780.79	Fatigue					☐	☐	☐	782.4	Jaundice		☐	☐	☐	460	Frequent Colds					GENITO-URINARY		
☐	☐	☐	780.6	Fever					☐	☐	☐	794.8	Liver Trouble		☐	☐	☐	477	Hay Fever		☐	☐	☐	788.36	Bed Wetting	
☐	☐	☐	784.0	Headache					☐	☐	☐	787.02	Nausea		☐	☐	☐	784.49	Hoarseness		☐	☐	☐	599.7	Blood in Urine	
☐	☐	☐	780.52	Loss of Sleep					☐	☐	☐	536.9	Stomach Pain		☐	☐	☐	478.1	Nasal Obstruction		☐	☐	☐	788.4	Frequent Urinati	
☐	☐	☐	783	Loss of Weight					☐	☐	☐	783.0	Poor Appetite		☐	☐	☐	784.7	Nosebleeds		☐	☐	☐	788.3	Lack of Bladder Control	
☐	☐	☐	799.2	Nervousness					☐	☐	☐	536.8	Poor Digestion		☐	☐	☐	379.91	Pain in Eyes							
☐	☐	☐	729.2	Neuralgia					☐	☐	☐	787.03	Vomiting		☐	☐	☐	368.9	Poor Vision		☐	☐	☐	590.9	Kidney Infection	
☐	☐	☐	780.8	Sweats					☐	☐	☐	578.0	Vomiting Blood		☐	☐	☐	461.9	Sinusitis		☐	☐	☐	788.1	Painful Urination	
☐	☐	☐	786.07	Wheezing					☐	☐	☐	783.5	Excessive Thirst		☐	☐	☐	462	Sore Throat		☐	☐	☐	601.9	Prostate Trouble	
☐	☐	☐	311	Depression					☐	☐	☐	536.8	Indigestion		☐	☐	☐	463	Tonsillitis							
									☐	☐	☐	569.3	Rectal Bleeding		☐	☐	☐	786.2	Persistent Cough							
															☐	☐	☐	787.2	Difficulty Swallowing							
															☐	☐	☐	523.8	Bleeding Gums							

			MUSCLES/JOINTS/BONES						CARDIO-VASCULAR						SKIN OR ALLERGIES						FOR WOMEN ONLY					
☐	☐	☐	724.5	Backache					☐	☐	☐	401.9	High Blood Pressure		☐	☐	☐	680.9	Boils		☐	☐	☐	625.3	Cramps or Backach	
☐	☐	☐	719.7	Foot Trouble					☐	☐	☐	458.9	Low Blood Pressure		☐	☐	☐	924.9	Bruising Easily		☐	☐	☐	626.2	Excessive Flow	
☐	☐	☐	550	Hernia					☐	☐	☐	786.51	Pain Over Heart		☐	☐	☐	701.1	Dryness		☐	☐	☐	627.2	Hot Flashes	
☐	☐	☐	719.1	Pain Between Shoulders					☐	☐	☐	785.9	Poor Circulation		☐	☐	☐	691.8	Eczema		☐	☐	☐	626.4	Irregular Cycle	
									☐	☐	☐	438	Previous Heart Trouble		☐	☐	☐	708.9	Hives or Allergy		☐	☐	☐	634.9	Miscarriage	
☐	☐	☐	724.6	Painful Tail Bone											☐	☐	☐	698.9	Itching		☐	☐	☐	625.3	Painful Periods	
☐	☐	☐	723.9	Stiff Neck					☐	☐	☐	785.0	Rapid Heart		☐	☐	☐	782.0	Sensitive Skin		☐	☐	☐	623.5	Vaginal Discharg	
☐	☐	☐	781.9	Spinal Curvature					☐	☐	☐	427.89	Slow Heart		☐	☐	☐	782.1	Skin Eruptions		☐	☐	☐	611.79	Lump in Breast	
☐	☐	☐	719.0	Swollen Joints					☐	☐	☐	436	Strokes								☐ Yes		☐ No		Pregnant at this tir	
☐	☐	☐	781.0	Tremors/Twitching					☐	☐	☐	719.7	Swelling Ankles								☐ Yes		☐ No		Have you had a mammogram?	
☐	☐	☐	782	Arm Trouble					☐	☐	☐	454	Varicose Veins												Last Pap Date	
																									By Whom	

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: _____

☐ I have never had any operations / surgeries

List any accidents or falls and dates: ☐ Car:_____ ☐ Recreation: _____
☐ Sports:_____ ☐ School:_____ ☐ Other: _____
List any broken bones (fractures) or dislocations:_____
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? ☐ Yes ☐ No
Have you ever had X-rays taken? ☐ Yes ☐ No 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? _____
Are you presently taking any medication - prescription or over-the -counter? ☐ Yes ☐ No 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 Off will prepare any necessary reports and forms to assist me in making collection form the in insurance company and that any amount authorized to be paid directly to the Doct 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 responsi 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, order or perform any necessary Laboratory/Diagnostic Imaging Tests and treat my condition as he deems approp through the use of chiropractic health care and nutritional/natural medicine therapies, and I give authority for these procedures/tests to be performed. 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 diagn conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____

CASE HISTORY

Name: _____ Age: _____ Date: _____ Case Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (Home): _____ Cell: _____ E-mail: _____
Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W # of Children: _____
Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
Insured's Name: _____ Phone: _____ Insured's Date of Birth: _____
Spouse's Name: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Spouse's Telephone (Work): _____
Past Chiropractic Care: ☐ Yes ☐ No When? _____ Doctor's Name: _____
Results: _____ Referred by: _____
Insurance Company: _____ Telephone: _____
Social Security Number: _____ Driver's License Number: _____ State: _____
Spouse's Insurance Company: _____ Telephone: _____
Spouse's Social Security Number: _____ Spouse's Driver's License Number: _____
Chief Complaint: 1. _____ Duration-(How Long): _____ Previous Episodes: _____
List Current: 2. _____ Duration-(How Long): _____ Previous Episodes: _____
Problems: 3. _____ Duration-(How Long): _____ Previous Episodes: _____

Are your present problems due to an injury? ☐ No ☐ Yes ☐ On the Job ☐ Auto Accident ☐ Personal Injury ☐ Other: _____
Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Auto Carrier ☐ Other: _____
Are you now or have you ever been disabled? (Service or Work)? ☐ No ☐ Yes When? _____ Why? _____
Have you retained an attorney? ☐ No ☐ Yes Name & Address: _____

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

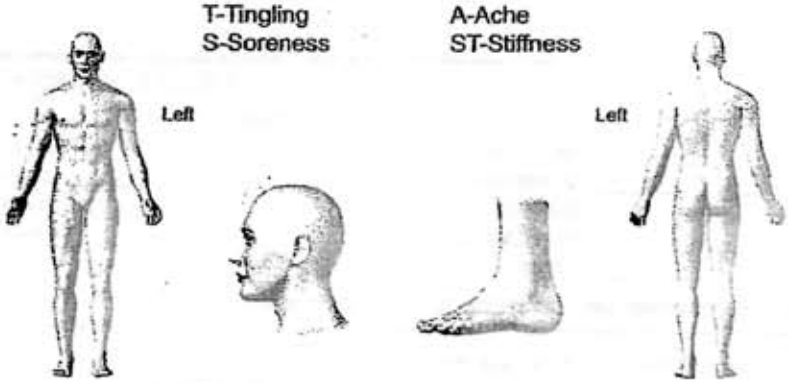
2. _____
1 2 3 4 5 6 7 8 9 10

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

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

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



DOCTORS USE ONLY

_____
_____
_____
_____

HABITS

☐ Smoking Packs/Day: _____
☐ Drinking Alcohol: _____
☐ Caffeine Cups/Day: _____

EXERCISE

☐ None
☐ Light Activity
☐ Moderate Activity
☐ Active
☐ Very Active
☐ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	☐	☐	☐	☐	☐ _____
Father	☐	☐	☐	☐	☐ _____
Brother,# of ___	☐	☐	☐	☐	☐ _____
Sister,# of ___	☐	☐	☐	☐	☐ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ 541	Appendicitis	☐ 280	Anemia	☐ 429.9	Heart Disease	☐ 716	Arthritis
☐ 480	Pneumonia	☐ 055	Measles	☐ 240	Goiter	☐ 345	Epilepsy
☐ 390	Rheumatic Fever	☐ 072	Mumps	☐ 487	Influenza	☐ 319	Mental Disorder
☐ 045	Polio	☐ 052	Chicken Pox	☐ 511	Pleurisy	☐ 724.2	Lumbago
☐ 011	Tuberculosis	☐ 250	Diabetes	☐ 303.9	Alcoholism	☐ 690	Eczema
☐ 033	Whooping Cough	☐ 239	Cancer	☐ 099	Venereal Disease	☐ 042	HIV Positive
☐ 493.9	Asthma	☐ 346.9	Migraine Headaches	☐ 054.9	Herpes	☐ 340	Multiple Sclerosis