

## CHIROPRACTIC CASE HISTORY

Today's Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Title: Mr. Mrs. Ms. Miss. Dr.

Full Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Name of Head of Household: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer's name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

Marital Status: ( ) M ( ) S ( ) D ( ) W Spouse's Name: \_\_\_\_\_

How did you choose our office? ( ) Insurance Booklet ( ) Telephone Book ( ) TV  
( ) Newspaper ( ) Another Doctor \_\_\_\_\_  
( ) From one of our Patients \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Are you here as a result of: ( ) Auto accident ( ) On the job injury ( ) Other

Have you been treated for this condition by another doctor? ( ) Yes ( ) No

If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_

What were you told \_\_\_\_\_

Please list any past surgeries, serious illnesses, or injuries: \_\_\_\_\_

Please list any current medications: \_\_\_\_\_

Do you have insurance: ( ) Yes ( ) No

Insurance Company Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Social security #: \_\_\_\_\_

Insured's Birthday: \_\_\_/\_\_\_/\_\_\_ Insured's Employer: \_\_\_\_\_

What is the relationship of the patient to the insured? (Ex: Spouse, child)

\_\_\_\_\_

1. Where is your problem? (Ex: neck, low back pain, headaches) \_\_\_\_\_
2. When did it start? \_\_\_\_\_
3. What caused it? \_\_\_\_\_
4. Have you had it before? \_\_\_\_\_ If so, when? \_\_\_\_\_
5. Is it getting worse? \_\_\_\_\_ Better? \_\_\_\_\_ Same? \_\_\_\_\_  
Please explain: \_\_\_\_\_
6. What makes it worse? \_\_\_\_\_
7. What makes it better? \_\_\_\_\_
8. How frequent is it? Constant \_\_\_\_\_ Daily \_\_\_\_\_ On & Off \_\_\_\_\_ Night time \_\_\_\_\_
9. Describe the pain: Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Burning \_\_\_\_\_ Tingling \_\_\_\_\_  
Stabbing \_\_\_\_\_ Numbness \_\_\_\_\_ Other \_\_\_\_\_
10. Are there any other symptoms that may be related to your problem? \_\_\_\_\_  
\_\_\_\_\_

What other treatment have you received for this problem? \_\_\_\_\_  
\_\_\_\_\_

12. Describe the severity of your problem by circling a number on the scale:

Mild    1    2    3    4    5    6    7    8    9    10    Severe

13. Have you lost any work as a result of your problem?    ( ) Yes    ( ) No  
From: \_\_\_\_\_ To: \_\_\_\_\_

Signature on file and authorization to release medical information:

I hereby authorize payment of insurance benefits directly to the doctor for service provided. I further authorize the doctor to release any information required to process insurance claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_