

# CASE HISTORY

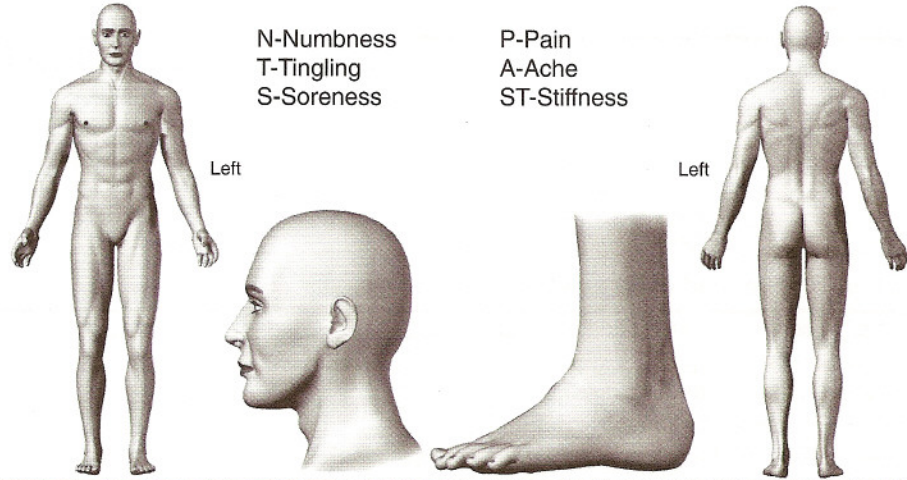
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Case Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone:(H) \_\_\_\_\_ (C) \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  D  W # of Children: \_\_\_\_\_  
 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: \_\_\_\_\_  
 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: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Contact Number \_\_\_\_\_

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: \_\_\_\_\_

Pain Symptoms: 1. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 (in order of 2. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 severity) 3. \_\_\_\_\_ Began-(Mo/Yr): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_

**Please mark the intensity of your pain today.**  
 0 - NO PAIN  
 10 - INTENSE PAIN  
 Example \_\_\_\_\_ Neck  
 O 1 2 3 ④ 5 6 7 8 9 10  
 1. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10  
 2. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10  
 3. \_\_\_\_\_  
 O 1 2 3 4 5 6 7 8 9 10

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



**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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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 the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_



**A&M CHIROPRACTIC WELLNESS CENTRE**  
**4012 S.W. Green Oaks Blvd**  
**Arlington, Texas 76017**  
**817-572-0072**

On a scale of 0-10 (0 equals no pain and 10 equals severe pain), place a number between 0 and 10 in each space for Frequency and Intensity. Only use one number not a range. (Example 5 not 4-6) Use a number that averages the last month. If you are on medications, use how you feel over the past month on these medications. Do not guess how you might feel without your medications.

Name:

		Frequency	Intensity
<b>Head</b>	Headache		
	Whole Head		
	Back of Head		
	Forehead		
	Right Temple		
	Left Temple		
	Migraine		
	“Heavy” Head		
	Memory Loss		
	Hearing Loss		
	Pain in Ears		
	Smell Loss		
	Taste Loss		
	Balance Loss		
	Eye Pain		
	Light Sensitivity		
	Dizziness		
	Ear Ringing		
	Ears Buzzing		
	Right Facial Pain		
	Left Facial Pain		
	Teeth Pain		
<b>Neck</b>	Neck Pain		
	Movement Pain		
	Feels Out		
	Neck Stiff		
	Muscle Spasm		
	Neck Grinds		
	Difficulty Swallowing		
	Popping		
	Nerve Feels Pinched		
<b>Shoulders/ Arms</b>	Right Shoulder Pain		
	Left Shoulder Pain		
	Across Shoulder Pain		

Name:

Frequency Intensity

	Cant Lift Arm Above Shoulder Level		
	Cant Lift Arm Over Head		
	Nerve Pain Right Shoulder		
	Nerve Pain Left Shoulder		
	Shoulder Spasm		
	Tense in Shoulder		
	Pain Right Forearm		
	Pain Left Forearm		
	Pain Right Hand Fingers		
	Pain Left Hand Fingers		
	Hands Cold		
	Swelling Right Hand		
	Swelling Left Hand		
	Pain Right Wrist		
	Pain Left Wrist		
	Pain Right Hand		
	Pain Left Hand		
	Pain Right Arm		
	Pain Left Arm		
	Arthritis Right Hand Fingers		
	Arthritis Left Hand Fingers		
	Weak Grip Right Hand		
	Weak Grip Left Hand		
<b>Mid Back/Chest</b>	Mid Back Pain		
	Pain Between Shoulder Blades		
	Spasms Mid Back		
	Chest Pain		
	Shortness of Breath		
	Pain in Right Ribs		
	Pain in Left Ribs		
<b>Low Back</b>	Low Back Pain		
	When Working		
	When Lifting		
	When Stooping		
	When Standing		
	When Sitting		
	When Bending		
	When Coughing		
	Low Back Out		
	Muscle Spasm		
	Arthritis		

		Frequency	Intensity
<b>Abdomen</b>	Nausea		
	Gas		
	Constipation		
	Diarrhea		
	Menstrual Pain		
	Cramping		
	Irregularity		
	Abdominal Pain		
<b>Hips/Legs/Feet</b>	Pain Right Buttocks		
	Pain Left Buttocks		
	Pain Right Hip		
	Pain Left Hip		
	Pain Right Thigh		
	Pain Left Thigh		
	Pain Right Leg		
	Pain Left Leg		
	Pain Right Ankle		
	Pain Left Ankle		
	Pain Right Foot		
	Pain Left Foot		
	Cramps Right Leg		
	Cramps Left Leg		
	Numb Right Leg		
	Numb Left Leg		
	Numb Right Foot		
	Numb Left Foot		
	Numb Toes (right foot)		
	Numb Toes (left foot)		
	Cold Right Foot		
	Cold Left Foot		
	Burning Right Foot		
	Burning Left Foot		
	Cramps Right Foot		
	Cramps Left Foot		
	Swollen Right Ankle		

Name \_\_\_\_\_

		Frequency	Intensity
	Swollen Left Ankle		
	Swollen Right Foot		
	Swollen Left Foot		
	Pain in Toes (right foot)		
	Pain in Toes (left foot)		
<b>General</b>	Fatigued		
	Teeth Grinding		
	Run Down		
	Insomnia		
	Restless Legs		
	Skin Itches		
	Wake Up Exhausted		
	Irritable Bowl Syndrome		
	Asthma or Hay Fever		
	Forgetful		
	Foggy Minded		
	Difficulty Breathing		
	Skin Sensitivity		
	Over All Body Pain		
	Nausea		
	Chronic Fatigue		
<b>Physiological</b>	Suicidal Feeling		
	Suicidal Plans		
	Suicidal Attempts(1 meaning seldom)		
	Depression		
	Panic Attacks		
	Nervousness		
	Anxiety		
	Irritable		
	Loss of Periods of Time		

Name: \_\_\_\_\_