CASE NO. _____

ADULT CASE HISTORY

(please print)

LAST NAME _____ FIRST NAME _____ MIDDLE _____

Address _____ City _____ State _____ Zip _____

Home phone ( ) _____ Work phone ( ) _____

Occupation _____ Employer _____

Social Security no. _____ Email: _____

Birth date _____ Age _____ Sex _____ Marital status ❑ S ❑ M ❑ D ❑ W

Spouses name _____ No. of children _____ Ages _____

Contact in case of emergency _____ Referred by _____

What is your major complaint? _____

_____

_____

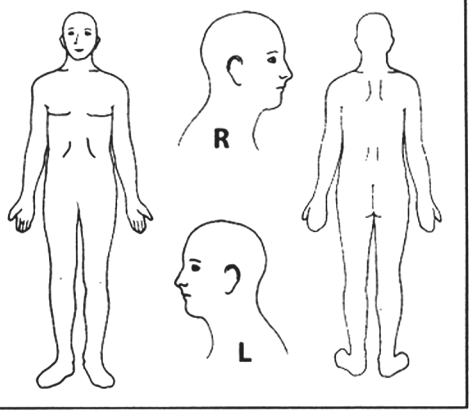
How long have you had this condition? _____ Have you had this or a similar condition in the past? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Did your injury occur while at work? ❑ Yes ❑ No When? _____

Other complaints? _____

Please mark your areas of pain on the figures below



✓ CHECK THE CONDITIONS THAT AFFECT YOU.

___ Neck problems
___ Grinding in neck
___ Shoulder problems
___ Tension across shoulders
___ Pain in arm
___ Wrist/elbow problems
___ Numbness in arms
___ Numbness in hands
___ Loss of grip strength
___ Headaches
___ Migraines
___ Sinus/Allergies
___ Dizziness
___ TMJ/Ear problems
___ Visual problems
___ Mid-back pain
___ Chest pain
___ Stomach problems
___ Asthma
___ Constipation/Gas
___ Diarrhea
___ Hemorrhoids
___ Low back pain
___ Disc problems
___ Pain in buttocks
___ Pain in hips
___ Pain in leg
___ Numbness in leg
___ Knee/Foot pain
___ Swollen ankles
___ Menstrual problems
___ Cramping/Irregular
___ Discharge
___ Urinary frequency
___ Difficulty in starting
___ Prostate pain/swelling
___ Nervous
___ Depressed/Fatigue
___ Diabetes/Hypoglycemia
___ High/Low Blood Pressure
___ Low Resistance/Colds
___ Kidney problems
___ Muscle Spasms
___ Other _____

- This is a ❑ new / ❑ old illness. It ❑ was / ❑ was not treated before.
  If treated before, what was done? _____
- Name of Doctors _____
- List surgeries _____
  _____
- Have you ever had Chiropractic care before? ❑ Yes ❑ No
  Name of Doctor _____ Date _____
- Last time you had spinal x-rays or other x-rays _____
- Medications you now take _____
  _____
- Are you pregnant? ❑ Yes ❑ No ❑ N/A

From birth to present, please list by date and describe.

1 Car accidents _____
_____
_____

2 Falls/Injuries (including sports) _____
_____
_____
_____

3 Other _____
_____
_____

Do you have Health Insurance? ❑ Yes ❑ No

Please give card to front desk C.A. for verification.

I clearly understand and agree that all first visit charges are payable when services are rendered.

Patient's Signature _____ Date _____

SHARE CHIROPRACTIC WITH YOUR FRIENDS AND FAMILY

NAME _____ **TYPE CASE** _____

Spinal care class: date attended _____

Cases referred by this patient (name & date) **1** _____

2 _____ **3** _____ **4** _____

5 _____ **6** _____ **7** _____

8 _____ **9** _____ **10** _____

Type Care: Instrument, Non Force, Light Force, Technique _____

ASSESS: **S** Same **I** Improving **W** Worse **A** Aggravated **N** New Condition

	SUBJECTIVE	OBJECTIVE						ADJUSTMENTS							ASSESS						PLAN
	P Pain **L** Left **S** Spasm **R** Right **H** Headache **NP** Neck Pain **MBP** Mid Back Pain **LBP** Low Back Pain **SHLD** Shoulder **SCAP** Scapula	Fixation/AB MO	Misalignment	Spasm/Edema	Muscle Weakness	Short Leg Prone	Short Leg Supine	**F** Full Spine	**C** Cervical	**T** Thoracic	**L** Lumbar	**S** Sacrum	**P** Pelvic	**E** Extremity	S I W A N	Acute	Corrective	Rehabilitative	Chronic	Exam X-Ray Frequency Referred Care
Date																					
1																					
2																					
3																					
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P - Pain
T - Tender
N - Numb
M - Hypoesthesia
S - Spasm
E - Edema

SEG	RIGHT	LEFT	RIGHT	LEFT
OCC				
C1				
2				
3				
4				
5				
6				
7				
D1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
L1				
2				
3				
4				
5				
SAC				
RIL				
LIL				
COC				

SYMBOLS: [C] CONSUL [/] ADJUS. [E] EXAM OR RE-EXAM [X] X-RAY OR RE-XRAY

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
JAN																																
FEB																																
MAR																																
APR																																
MAY																																
JUN																																
JUL																																
AUG																																
SEP																																
OCT																																
NOV																																
DEC																																

NAME _____ **PATIENT NO.** _____

	EXAM 1	EXAM 2	EXAM 3	EXAM 4
DATE				
X-RAY VIEWS				

SITTING

	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
Biceps								
Triceps								
Patellar Reflex								
Foramina Compression								
Shoulder Depressor								

SUPINE

	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
Lasegues								
Braggards								
Leg Raise/Lower								
Fabere Patrick								
Soto Hall								

PRONE

	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
Achilles Reflex								
Apparent Short Leg								
Head Turn								
Derefield Test								
Eli Test								

CERVICAL ROM

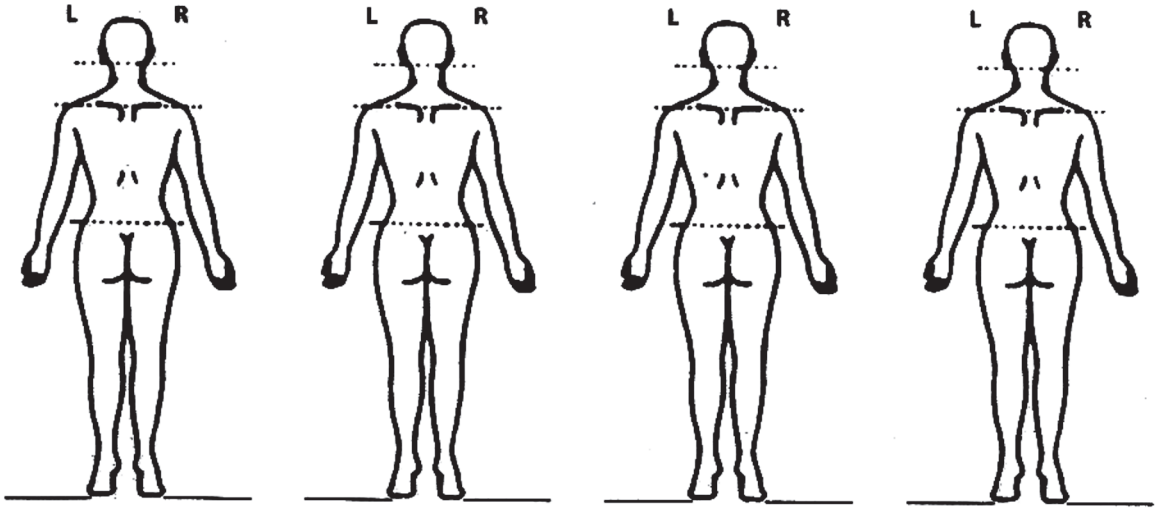
	NORM	PASS	PAIN	NORM	PASS	PAIN	NORM	PASS	PAIN	NORM	PASS	PAIN
Flexion	45			45			45			45		
Extension	55			55			55			55		
Lat. R. Flexion	40			40			40			40		
Lat. L. Flexion	40			40			40			40		
Right Rotation	70			70			70			70		
Left Rotation	70			70			70			70		

LUMBAR ROM

	NORM	PASS	PAIN	NORM	PASS	PAIN	NORM	PASS	PAIN	NORM	PASS	PAIN
Flexion	70			70			70			70		
Extension	30			30			30			30		
Lat. R. Flexion	35			35			35			35		
Lat. L. Flexion	35			35			35			35		
Right Rotation	30			30			30			30		
Left Rotation	30			30			30			30		

Pinwheel C5 C6 C7 T1 L4 L5 S1 Other

Other _____



NAME _____ **PATIENT NO.** _____

ABBREVIATION KEY

X-RAYS: **LC** Lateral Cervical **LL** Lateral Lumbar **APOM** Anterior Posterior Open Mouth **APL** Anterior Posterior Lumbar **OBL** Oblique

L Left ⊖ Negative ↑ Increase C̄ With **WK** Week @ At **X** Number of times
R Right ⊕ Positive ↓ Decrease **W/O** Without **MO** Month ○ Absent

AB	Abnormal	**CC**	Chief Complaint	**POSS**	Possible	**TRAP**	Trapezius
ABD	Abdominal	**FX**	Fracture	**PT**	Physical Therapy	**TMJ**	Tempro Mandibular Joint
AI	Anterior Ilium	**MMI**	Maximun Medical Improvement	**PROG**	Prognosis	**AB MO**	Aberrant Motion
AP	Anterior Posterior	**MOD**	Moderate	**R/O**	Rule Out		
ASAP	As Soon As Possible	**OCC**	Occiput	**ROM**	Range Of Motion		
BP	Blood Pressure	**PI**	Posterior Ilium	**SI**	Sacroiliac Joint		

PAIN SCALE

0	2	4	6	8	10
NO PAIN	MILD	DISCOMFORTING	DISTRESSING	HORRIBLE	EXCRUCIATING

REMARKS:

Ins. Co. _____ ❑ Cervical pillow ❑ Lumbar support

Secondary _____ ❑ Patient testimonial date _____

Ded _____ M _____ NM _____ ❑ Exercises _____

Benefits _____ ❑ Vitamins _____

X-ray _____ ❑ Handouts _____

DIAGNOSIS

EXAM 1 _____

EXAM 2 _____

EXAM 3 _____

EXAM 4 _____