Case No. ________________

LAST NAME ____________________ FIRST NAME ____________ MIDDLE ____________

ADDRESS ____________________ SS# ____________ BIRTHDATE ________ AGE ______

CITY ____________ STATE ______ ZIP ________ DL# ____________________

OCCUPATION ____________________ SPOUSE ____________________

EMPLOYER ____________________ SPOUSE'S OCCUPATION ____________________

OF CHILDREN ______ PHONE ____________ WORK ____________ CELL ____________ EMAIL ____________

Contact in case of emergency ____________________ REFERRED BY ____________________

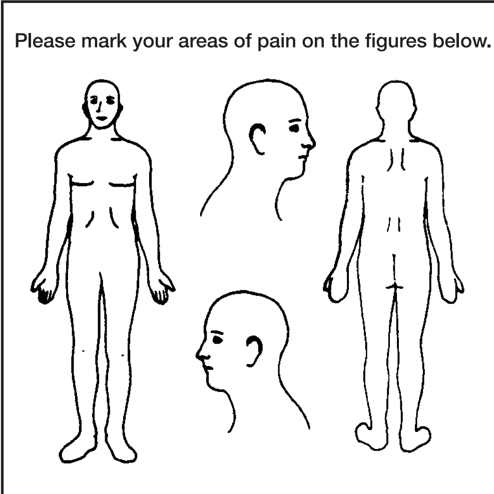
What is your major complaint? ____

Other complaints? ____

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 ❑

Please mark your areas of pain on the figures below.



- ____ Neck Problems
- ____ Shoulder Problems
- ____ Arm Problems
- ____ Numbness - Arms
- ____ Pain Between Shoulders
- ____ Low Back Problems
- ____ Leg Problems
- ____ Numbness - Legs
- ____ Loss of Feeling
- ____ Stiff Joints
- ____ Painful Joints
- ____ Restricts Daily Activities
- ____ Restricts Regular Exercise

- ____ Sore Muscles
- ____ Walking Problems
- ____ Broken Bones
- ____ Muscle Cramps
- ____ Weak Muscles
- ____ Headaches
- ____ Dizziness
- ____ Fainting
- ____ Forgetfulness
- ____ Depression
- ____ Vision Problems
- ____ Ear Pain / Noises
- ____ Ear Infections
- ____ Hearing Loss
- ____ Frequent Colds

- ____ Allergies
- ____ Hay Fever
- ____ Asthma
- ____ Exzema
- ____ Shingles
- ____ Nausea
- ____ Poor Digestion
- ____ Ulcers
- ____ Diarrhea
- ____ Constipation
- ____ Kidney Infection
- ____ Menstrual Cramps
- ____ Diabetes
- ____ Blood Pressure High / Low
- ____ Tiredness / Fatigue

- This is a new / old illness. It was not / was treated before. If treated before, what was done? ____________
- Name of Doctors: ____________
- Have you ever had surgery or been hospitalized? ❑ Yes ❑ No
  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: ____________

- Female: Are you pregnant at this time? ❑ Yes ❑ No Due Date ________

From birth to present please list by date / describe

1) Car Accidents ____________

2) Falls / Injuries (Including Sports) ____________

3) Other ____________

Sign & Date:

(FOR DOCTORS USE ONLY)

CERVICAL	Norm	Date 1	Date 2	Date 3	Date 4
Flexion	50				
Extension	60				
Lat. R. Flex	45				
Lat. L. Flex	45				
Rotation Right	80				
Rotation Left	80				

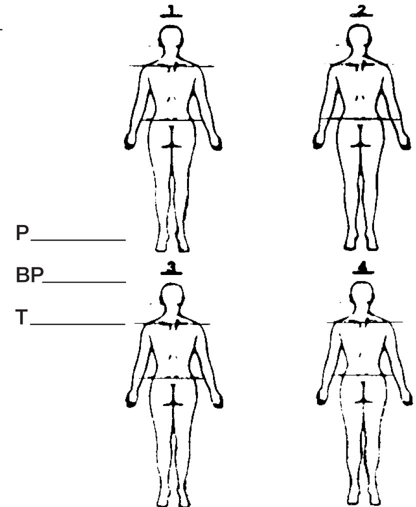
LUMBAR	Norm	Date 1	Date 2	Date 3	Date 4
Flexion	60				
Extension	25				
Lat. R. Flex	25				
Lat. L. Flex	25				
Rotation Right	30				
Rotation Left	30				

Test	1 L	1 R	2 L	2 R	3 L	3 R	4 L	4 R
F. Compression								
Shoulder Depression								
Kemps								
SLR								
Soto Hall								
Ely's								
Toe Walk								
Heel Walk								
Derefield Test								
Weight Distribution								
Dec. Int. Hip Rot.								
Dynanometer								

P ________

BP ________

T ________



Height ________ Weight ________

Comments ____