



**CASE HISTORY**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F Marital Status: S M D W  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Occupation Employer \_\_\_\_\_ Phone (Work) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Insured's ID. # or S.S. # \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Spouse's Phone (Work) \_\_\_\_\_  
Spouse's Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_  
Spouse's Social Security # \_\_\_\_\_  
Present condition due to an injury?  Yes  No  On the Job  Auto Accident  Other \_\_\_\_\_  
Has the accident been reported?  Yes  No  To Employer  Auto Carrier  Other \_\_\_\_\_

**HEALTH HISTORY**

Reason for seeking care: \_\_\_\_\_  
List any other doctors seen for this: \_\_\_\_\_  
List any diagnosis and type of treatment: \_\_\_\_\_  
Have you had similar accidents or injuries before?  Yes  No If yes, explain: \_\_\_\_\_  
List the names of any relatives that have or have had a similar problem: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ File: \_\_\_\_\_

Have you or any relative received chiropractic treatment previously? \_\_ Yes \_\_ No

If yes, explain: \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? \_\_ Yes \_\_ No

If yes, explain: \_\_\_\_\_

Are you currently taking medication? \_\_ Yes \_\_ No list medications: \_\_\_\_\_

Have you taken medication in the past? \_\_ Yes \_\_ No list medications \_\_\_\_\_

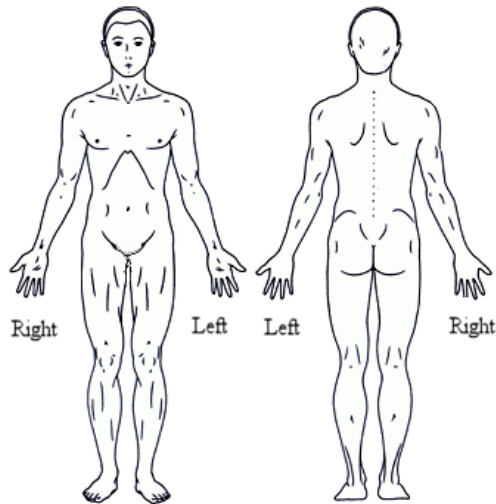
List conditions you are taking medications for: \_\_\_\_\_

List the approximate dates of any surgery, treated conditions, or hospitalizations: \_\_\_\_\_

Do you smoke Y/N \_\_\_\_\_ •Alcohol Y/N \_\_Daily \_\_ Weekly \_\_ Social Occasions •Caffeinated drinks per day \_\_\_\_\_

Do you take Vitamins/Supplements Y/N If yes, type and how often

Please circle degree of pain, 0 none, 10 severe pain.



0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =  
Dull Ache OOO  
Burning XXX  
Sharp/Stabbing ///  
Pins, Needles +++  
Other \_\_\_\_\_ ^^ ^

What activities aggravate your condition/pain?  
\_\_\_\_\_

What activities lessen your condition/pain?  
\_\_\_\_\_

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition progressively getting worse? \_\_\_\_\_

**Stress:** Please rate your stress management strategies: Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

Please rate your daily stress Level: None 1 2 3 4 5 6 7 8 9 10 Terrible

**Pregnancy:** # of pregnancies \_\_\_\_\_ # Birth Children \_\_\_\_\_ N/A \_\_\_\_\_

**Please Help Us To Identify Your Potential Health Risks By Placing a Check In any Column That Applies To You Or Your Blood Relatives**

Condition/Body System	Self	Grandparent	Parent	Sibling	Child
Aids/HIV					
Arthritis					
Bleeding Disorders					
Cancer					
Endocrine/Glandular (diabetes/Thyroid)					
Hepatitis					
Immune					
Stroke/TIA					
Circulatory Problems (blood vessels, heart)					
Ear, Nose, Throat					
Heart Problems					
High Blood Pressure					
Neurological					
Gastrointestinal (stomach, Intestines)					
Muscle/Joint/Bone					
Genitourinary (urine, kidney, prostate)					
Psychological					
Respiratory (Lung, breathing)					
Skin					

The above information is true to the best of my knowledge. I assign directly to Kelly Chiropractic and Rehabilitation, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize my doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X \_\_\_\_\_ / / \_\_\_\_\_  
 Patient/Guardian Signature Date