Check beside condition(s) if you have had within the PAST YEAR:

GENERAL SYMPTOMS
____ Headache
____ Fever
____ Chills
____ Night Sweats
____ Fainting
____ Dizziness
____ Convulsions
____ Loss of Sleep
____ Fatigue
____ Nervousness
____Loss of Weight
____Numbness or pain in arms/legs/hands
____ Allergies
____ Wheezing
____ Neuralgia

GASTRO-INTESTINAL
____Poor Appetite
____ Poor Digestion
____ Excessive Hunger
____ Belching or Gas
____Nausea
____Vomiting
____Vomiting Blood
____Pain over Stomach
____Constipation
____ Diarrhea
____Colon Trouble
____ Hemorrhoids
____ Liver Trouble
____ Jaundice
____ Gall Bladder Trouble

EYE/EAR/NOSE/THROAT
____ Poor Vision
____ Crossed Eyes
____ Pain in Eyes
____ Deafness
____ Earache
____ Ear Noises
____ Ear Discharges
____ Nasal Obstruction
____ Nose Bleeds
____Sore Throat
____ Hoarseness
____ Hay Fever
____ Asthma
____Enlarged Thyroid
____ Tonsilitis
____Sinus Trouble

RESPIRATORY
____ Chronic Cough
____ Spitting Blood
____Spitting Phlegm
____ Chest Pain
____ Difficulty Breathing

GENITO-URINARY
____ Frequent Urination
____ Painful Urination
____ Blood in Urine
____Kidney Infection
____ Bed Wetting
____ Inability to control Urine
____ Prostate Trouble

MUSCLE & JOINTS
____ Weakness
____Twitching
____Stiff Neck
____ Backache
____Swollen Joints
____Tremors
____ Foot Trouble
____ Painful Tail Bone
____ Pain between Shoulders
____ Hernia

CARDIO-VASCULAR
____Rapid Heart
____ Slow Heart
____ High Blood Pressure
____ Low Blood Pressure
____ Pain over Heart
____Previous Heart Trouble
____ Swelling Ankles
____ Poor Circulation
____ Varicose Veins
____Strokes

SKIN OR ALLERGIES
____ Skin Eruptions
____ Itching
____ Bruising Easily
____ Dryness
____ Boils
____Sensitive Skin
____ Hives or Allergy
____ Eczema

FOR WOMEN ONLY
____ Painful Periods
____ Excessive Flow
____ Irregular Cycle
____ Hot Flashes
____ Cramps or Backaches
____ Miscarriage
____ Vaginal Discharge
____ Pregnant at this time

OPERATIONS AND PROCEDURES

	Date		Date		Date
Vaccinations		Tubes in ears		Sinus Surgery	
Tonsilectomy		Appendectomy		Hernia	
Gall Bladder		Female organs		Thyroid	
Back Surgery		Rectal Surgery		Stomach	
Other		Other		Other	

List any accidents or falls and dates: □Car: _____ □Recreational Vehicle: _____
□Sports: _____ □School: _____ □Other:_____
List any broken bones or dislocations (fractures):
_____
Ever on crutches? □No □Yes If yes, why?
_____
Have you ever had any spinal taps or spinal injections? □Yes □No
Were you ever knocked unconscious? □Yes □No
Do you suffer from any condition other than that for which you are now consulting us?
_____
Are you presently taking any medication-prescription or patent? □No □Yes If yes, what drugs and dosage?
_____
_____
Are you allergic to anything? If Yes, what is the object and reaction?
_____

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I understand and agree that any balance shall be paid promptly by me, the patient, in accordance with terms and agreements, and that The Fix may add one- and one-half percent (1 ½%) per month to any balance owed, and in the event of default, I may be charged reasonable collection charges and/or attorney fees.

Patient's Signature: _____ Date: _____

The Fix **CONFIDENTIAL CASE HISTORY** **Date: _____/_____/_____**

Name: _____
First Middle Last Nickname

Home address: _____ Birth date: _____/_____/_____

City: _____ State: _____ Zip code: _____ Home Phone: (____)-_____

Work Phone: (____)-_____ Cell: (____)-_____ E-mail: _____

Sex: □M □F Marital Status: □S □M □D □W Social Security Number: _____

Race: □ White □ African-American □ Hispanic □ Asian □ Other: _____

Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino Preferred Language: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip code: _____

Name of spouse (or responsible party if patient is a dependent child): _____

Spouse's (responsible party's) birth date: _____/_____/_____Social Security Number: _____

Spouse's Employer: _____ Occupation: _____

Referred by: _____ Past Chiropractic Care: □Yes □No When? _____

Doctor's name: _____ Results: _____

Chief complaint(s): 1._____

2._____

3._____

Are your present injuries due to an injury? □No □Yes □On the job □Auto accident □Personal injury □Other

Have you made a report of your accident? □No □Yes □To employer □Auto carrier □Other: _____

Has this accident been reported? □No □Yes □Worker's Comp. □Auto carrier □Other: _____

Are you now or have you ever been disabled? (Service work) □No □Yes When? _____

Have you retained an attorney? □No □Yes Name & Address: _____

PLEASE GIVE MOST CURRENT DATE

Spinal Exam: _____

MRI Exam: _____

X-ray Exam: _____

Lab Exam: _____

Last Physical: _____

FEMALE ONLY

Pap smear: _____

Breast Exam: _____

Implants: _____

DOCTOR'S USE ONLY

_____

_____

_____

_____

_____

Severity of Pain

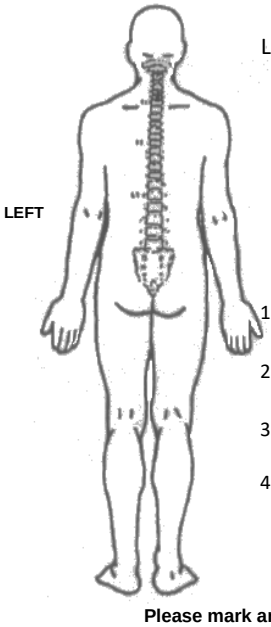
List region of pain and circle severity number. 1=least, 10=greatest

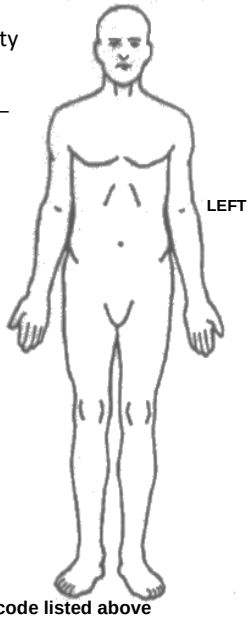
ex. Neck

1 2 3 4 5 6 7 8 9 10

MARK PAIN AREA

+++ Burning
000 Stabbing
- - - Sharp
III Constant





1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above

HABITS

□Smoking Packs/day: ____
□Drinking Alcohol: ____
□Coffee Cups/day: ____
□Never smoker
□Former smoker

EXERCISE

□None
□Moderate
□Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	□	□	□	□	□
Father	□	□	□	□	□
Brother, # of__	□	□	□	□	□
Sister, # of___	□	□	□	□	□

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

□Appendicitis □Anemia □Heart Disease □Arthritis
□Pneumonia □Measles □Goiter □Epilepsy
□Polio □Chicken Pox □Pleurisy □Lumbago
□Tuberculosis □Diabetes □Alcoholism □Eczema

Continued on back ⟹