

PERSONAL CASE HISTORY

Date \_\_\_\_\_

Name: \_\_\_\_\_ Marital /Partner Status: \_\_\_\_\_  
last first mid.int.

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best Phone # to Reach You: \_\_\_\_\_ Second Phone #: \_\_\_\_\_

Date of birth(month-day-year): \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

No. of Children (childbirths): \_\_\_\_\_ Name of Spouse/Partner: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Business Phone (if it applies) : \_\_\_\_\_ E-Mail \_\_\_\_\_

If minor, name of your parents: \_\_\_\_\_

Have you ever received chiropractic care before? \_\_\_\_\_ When (last time): \_\_\_\_\_

What doctor or clinic? \_\_\_\_\_

Describe the main health problems for which you came to this office: \_\_\_\_\_

List any doctor(s) or clinic(s) you have been to for these problems: \_\_\_\_\_

List any diagnosis(es) or type of treatment(s): \_\_\_\_\_

List any accident(s) or personal injury(ies) you have ever had in the past (when?): \_\_\_\_\_

List any broken bones you have ever had (when?): \_\_\_\_\_

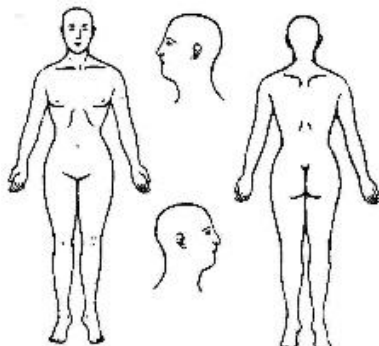
List any serious health problems/diseases you have had or may have now: \_\_\_\_\_

List any operations you have ever had (when?): \_\_\_\_\_

Have you ever been hospitalized for anything other than an operation? (when and for what?): \_\_\_\_\_

Have you ever had a nervous breakdown or serious depression? \_\_\_\_\_

List any serious health problems suffered by your immediate side of the family: \_\_\_\_\_



\_\_\_\_\_ When was the last time you had an X-ray picture taken of you (any type)?

\_\_\_\_\_ List any medications you are taking presently: \_\_\_\_\_

\_\_\_\_\_ List any vitamins or nutrients you are taking presently: \_\_\_\_\_

\_\_\_\_\_ Referred by: \_\_\_\_\_

← Please mark (X) your areas of pain .