

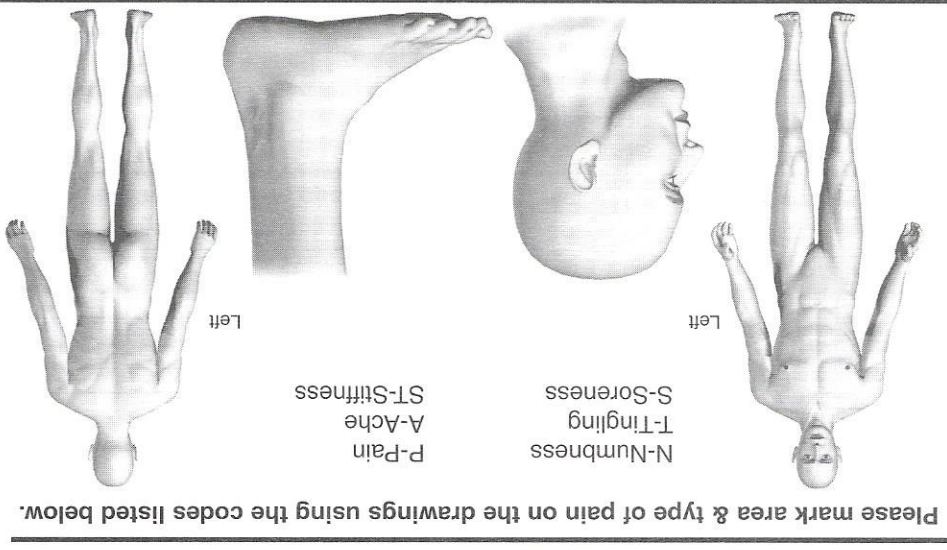
CASE HISTORY

Name: _____ Age: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone:(H) _____ (C) _____ Fax: _____ E-mail: _____
 Date of Birth: _____ Sex: M F S M D W # of Children: _____
 Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
 Insured's Name: _____ Phone: _____ Insured's Date of Birth: _____
 Spouse's Name: _____ Spouse's Occupation: _____
 Spouse's Employer: _____ Spouse's Telephone (Work): _____
 Past Chiropractic Care: Yes No When? _____
 Doctor's Name: _____ Referred by: _____
 Insurance Company: _____ Telephone: _____
 Spouse's Insurance Company: _____ Telephone: _____
 Spouse's Social Security Number: _____
 Emergency Contact: _____ Relationship: _____ Contact Number: _____
 Are your present problems due to an injury? No Yes On the job Auto Accident Personal Injury Other: _____
 Has the accident been reported? No Yes To Employer Auto Carrier Other: _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When? _____ Why? _____
 Have you retained an attorney? No Yes Name & Address: _____

Pain Symptoms: 1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 (in order of severity) 2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

Please mark the intensity of your pain today.

Example	0	1	2	3	4	5	6	7	8	9	10
10 - INTENSE PAIN	0	1	2	3	4	5	6	7	8	9	10
0 - NO PAIN	0	1	2	3	4	5	6	7	8	9	10
1.	0	1	2	3	4	5	6	7	8	9	10
2.	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10



HABITS
 Smoking Packs/Day: _____
 Drinking Alcohol: _____
 Caffeine Cups/Day: _____

EXERCISE
 None
 Light Activity
 Moderate Activity
 Active
 Very Active
 Elite Athlete

FAMILY HISTORY
 Mother Diabetes Heart Kidney Cancer Other _____
 Father Diabetes Heart Kidney Cancer Other _____
 Brother, # of: _____
 Sister, # of: _____

- HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?**
- | | | | |
|--|---|---|---|
| <input type="checkbox"/> 541 Appendicitis | <input type="checkbox"/> 280 Anemia | <input type="checkbox"/> 429.9 Heart Disease | <input type="checkbox"/> 716 Arthritis |
| <input type="checkbox"/> 480 Pneumonia | <input type="checkbox"/> 055 Measles | <input type="checkbox"/> 240 Gout | <input type="checkbox"/> 345 Epilepsy |
| <input type="checkbox"/> 390 Rheumatic Fever | <input type="checkbox"/> 072 Mumps | <input type="checkbox"/> 487 Influenza | <input type="checkbox"/> 319 Mental Disorder |
| <input type="checkbox"/> 045 Polio | <input type="checkbox"/> 052 Chicken Pox | <input type="checkbox"/> 511 Pleurisy | <input type="checkbox"/> 724.2 Lumbago |
| <input type="checkbox"/> 011 Tuberculosis | <input type="checkbox"/> 250 Diabetes | <input type="checkbox"/> 303.9 Alcoholism | <input type="checkbox"/> 690 Eczema |
| <input type="checkbox"/> 033 Whooping Cough | <input type="checkbox"/> 239 Cancer | <input type="checkbox"/> 099 Venereal Disease | <input type="checkbox"/> 042 HIV Positive |
| <input type="checkbox"/> 493.9 Asthma | <input type="checkbox"/> 346.9 Migraine Headaches | <input type="checkbox"/> 054.9 Herpes | <input type="checkbox"/> 340 Multiple Sclerosis |
- (OVER)

Panther Chiropractic, LLC
 4950 William Penn Hwy.
 Export, Pa 15632
 724-387-1014