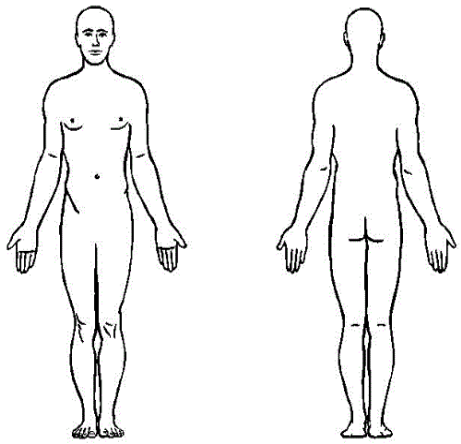
HAYNES CHIROPRACTIC Confidential Case History Patient #:_____

NAME_____ SS#:_____-_____-_____ DATE_____
ADDRESS_____ PHONE #(____)_____
CITY_____ STATE_____ ZIP_____ WORK # (____)_____
BIRTHDATE_____ AGE_____ SEX: M F STATUS: S M D W CELL # (____)_____
OCCUPATION_____ SPOUSE_____ # OF CHILDREN_____
E-MAIL_____ REFERRED BY_____# of Pregnancies:_____

Is the condition due to an accident? Yes No Type of accident: Auto Work Home Other_____
Date of accident:_____ To whom have you made a report?_____ Attorney:_____

Major complaints and symptoms: How long?
1._____
2._____
3._____
4._____
5._____

MARK THE AREAS OF PAIN



Is this condition getting worse? Yes □ No □ Constant □ Comes and goes □
Does it interfere with your Work □ Sleep □ Daily Routine □ Recreation □
What aggravates your condition?
Sitting □ Standing □ Walking □ Bending □ Lying Down □ Twisting □
What treatment have you already received for your condition?
Medications □ Surgery □ Physical Therapy □ Chiropractic □
Home remedies:_____
Medications you now take:_____
Date of last Physical Exam:_____
Date of last Dental Exam:_____

Injuries/Surgeries you have had
Falls / Injuries _____
Car Accidents _____
Illness lasting more than a few days _____
Hospitalizations/Surgeries _____
Other Accidents _____
_____

Circle any that you have had:

Allergies	Anemia	Appendicitis	Arthritis	Asthma	Stroke	Hearing Problems
Cancer/Tumors	Diabetes	Emphysema	Gout	Heart Disease	Tonsillitis	Sinus Problems
Hernia	Herniated Disk	High Cholesterol	Migraine Headaches	Miscarriage	Ulcers	Vaginal Infections
Multiple Sclerosis	Osteoporosis	Fibromyalgia	Pinched Nerve	Constipation	Thyroid	Dizziness

Exercise None □ 1-2/week □ 3-4/week □ 5-6/week □ Daily □ Heavy Training □
Do you have difficulty Sleeping? Y N _____ Are you under emotional Tension/Stress Y N _____
Tobacco: Packs/day_____ Alcohol: Drinks/Week_____ Coffee/Caffeine Drinks: Cups/Day_____
Chocolate/Sugar:_____ Soda: Oz./Day_____ Salt:_____ Bread: How Often?_____
Do you eat Breakfast? Y N Water: Oz./Day_____ Energy Level: Good Fair Poor
Days/Week you eat: Meat_____ Veggies_____ Green Salad_____ Grains/Pasta_____ Dessert_____ Fast Food___
Medications:_____ _____ _____ _____ _____
Vitamins/Herbs:_____ _____ _____ _____ _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment any fees for professional sevices rendered to me will be immediately due and payable. I consent to treatment at Haynes Chiropractic LLC.

Signature of Patient, Parent or Guardian:_____ **Date**:_____