Kelly Chiropractic and Rehabilitation Center, LLC

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: _____

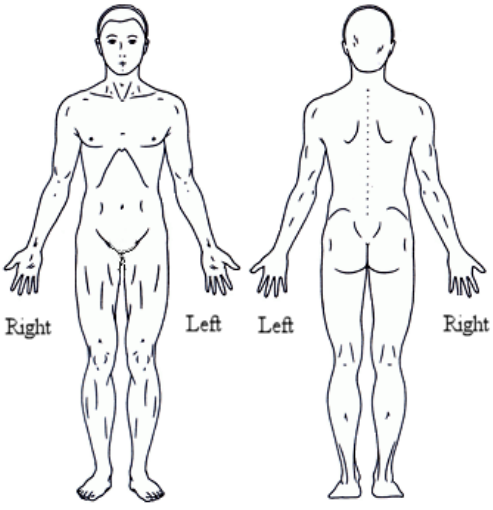
_____

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 ToIdentify 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