



Profitt Chiropractic Call TODAY
(606) 326-0100

4360, 13th Street, Suite 2, Ashland, KY 41102

CASE HISTORY (1-4)

Name: _____ Age: _____ Date: _____ Case Number: _____

Address: _____ City: _____ Zip: _____

Phone (home): _____ Date of Birth: _____ Sex: M F

Marital Status: S M D W # Children: _____

Occupation: _____ Employer: _____ Telephone (work): _____

Insured's Name: _____ Phone: _____ Insured's Date of Birth: _____

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Spouse's Telephone (work): _____

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

Doctor's Name: _____ Results: _____

Insurance Company: _____ Telephone: _____

Social Security Number: _____ Driver's License #: _____ State: _____

Spouse's Insurance Company: _____ Telephone: _____

Spouse's Social Security Number: _____ Spouse's Driver's License # _____

Chief Current: 1. _____ Duration-(How Long): _____ Previous Episodes: _____

List Current 2. _____ Duration-(How Long): _____ Previous Episodes: _____

Problems 3. _____ Duration-(How Long): _____ Previous Episodes: _____

Are your present problems due to an injury? No Yes On 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)? Yes No When? _____

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



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CASE HISTORY (2-4)

Name: _____ Age: _____ Date: _____ Case Number: _____

Please mark the intensity of your pain today. 1- NO PAIN 10-MOST INTENSE EVER FELT

1 2 3 4 5 6 7 8 9 10

List any accidents or falls and dates:

- Car: _____
- Recreation Vehicle: _____
- Sports: _____
- School: _____
- Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? Yes No Why? _____

Have you ever had any spinal taps or spinal injections? Yes No

Were you ever knocked unconscious? Yes No

Have you ever a laps of memory? Yes No

Have you ever had X-rays taken? Yes No

When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication – prescription or over-the-counter? Yes No

What drugs? _____

What other factors of your health have you not revealed perhaps because you are embarrassed by them, if any?



CASE HISTORY (3/4)

It is important for the doctor to know of your past history. Please check all that apply to your past medical history.

General Symptoms

- Allergy (what) _____
- Bronchitis
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Neuralgia
- Night Sweats
- Numbness or pain
in arms/legs/hands
- Wheezing

Gastro-Intestinal

- Belching or Gas
- Colon trouble
- Constipation
- Diarrhea
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting blood

Eye/Ear/Nose/Throat

- Asthma
- Crossed eyes
- Deafness
- Earache
- Ear discharge
- Enlarged thyroid
- Frequent colds
- Hay fever
- Hoarseness
- Nasal Obstruction
- Nose bleeds
- Pain in eyes
- Poor vision
- Sinusitis
- Sore throats
- Tonsillitis

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting blood
- Spitting phlegm

Cardio-Vascular

- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Previous heart trouble
- Rapid heart
- Slow heart
- Strokes
- Swelling ankles
- Varicose veins

Skin or Allergies

- Boils
- Bruising easily
- Dryness
- Eczema
- Hives or allergy
- Itching
- Sensitive skin
- Skin eruptions

Genito-Urinary

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control urine
- Kidney Infection
- Painful urination
- Prostate trouble

For Women Only

- Cramps or Backaches
- Excessive flow
- Hot flashes
- Irregular cycle
- Miscarriage
- Painful periods
- Vaginal Dryness
- Pregnant at this time
- Last Pap Date
- By Whom



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CASE HISTORY (4/4)

OPERATIONS AND PROCEDURES

DATE:

DATE:

DATE:

| | | |
|----------------------|----------------------|--------------------|
| _____ Vaccinations | _____ Tubes in ears | _____ Sinus |
| _____ Tonsillectomy | _____ Appendectomy | _____ Hernia |
| _____ Gall bladder | _____ Female organs | _____ Thyroid |
| _____ Back Operation | _____ Rectal surgery | _____ Stomach |
| _____ Other: _____ | _____ Other: _____ | _____ Other: _____ |

_____ I have never had any operations/surgeries

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Profitt Chiropractic, PLLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Brad Profitt will be credited to my account on receipt. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize Dr. Brad Profitt 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. It is understood and agreed the amount paid to Dr. Brad Profitt for X-Rays is for examination only and the X-Ray negatives will remain the property of Profitt Chiropractic, PLLC, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. Dr. Profitt will not be responsible for any pre-existing medically diagnosed conditions nor for medical diagnosis.

Patient's/Guardian's Signature: _____

Date: _____