CHIROPRACTIC RECORD

CASE NO. _____ PATIENT'S NAME _____

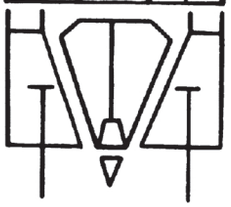
ADDRESS _____ DATE _____

TEL. NO. _____ REFERRED BY _____ OCCUPATION _____ AGE _____ SEX _____ S.M.W.D.

INSURANCE _____

SPINAL ANALYSIS

X-Ray	Palpation		Palpation	X-Ray
		Occ		
		At		
		Ax		
		3C		
		4		
		5		
		6		
		7		
		1D		
		2		
		3		
		4		
		5		
		6		
		7		
		8		
		9		
		10		
		11		
		12		
		1L		
		2		
		3		
		4		
		5		



FAMILY HISTORY: FATHER _____ MOTHER _____

BROTHERS _____ SISTERS _____

AILMENTS _____

PAST HISTORY: ILLNESSES _____

MENSTRUAL _____

MARITAL _____

HABITS _____

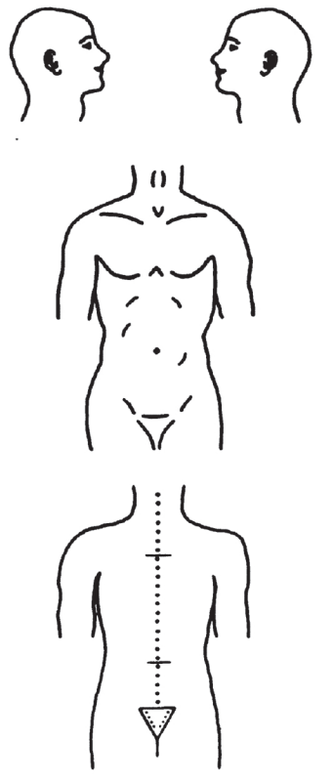
PRESENT AILMENT: _____

PHYSICAL EXAMINATION: TEMP. _____ PULSE _____ RESP. _____

B.P. _____ HT. _____ WT. _____ GENERAL APPEARANCE _____

REMARKS: _____

LOCALIZATION



SAMPLE

#C-104
MISSION PRINTING (559) 227-7640 • (800) 693-2108

PATIENT'S NAME _____ DIAGNOSIS _____

TREATMENT

DATE			SUBSEQUENT VISITS AND FINDINGS
MO.	DAY	YR.	