

Case History

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone _____ Date of Birth _____ (Age _____)

Referred by _____ Social Security# _____

Occupation _____ Marital Status S M D W

Employer _____ Spouse's Name _____

Have you ever received Chiropractic Care? Yes No Spouse's Occupation _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damaged your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness

			Patient Comment if answer is YES	Chiropractor's Comments
Yes	No	<u>YOUR BIRTH PROCESS</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Was your birth delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was your birth difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breech/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during the delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
Yes	No	<u>YOUR GROWTH AND DEVELOPMENT</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when you sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down the stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other childhood traumas?	_____	_____
Yes	No	<u>CURRENT HEALTH HABITS</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Did/Do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/Do you drink alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you eat healthy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back	_____	_____

Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	Car accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Organs removed/replaced?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs (prescriptive or non-prescriptive?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Problems sleeping? (insomnia, nightmares?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____

Present State of Symptoms and Ill Health

PRESENT COMPLAINT

Major Complaint _____

Pain or problem started _____ Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Relationships?: _____

Is this condition getting progressively worse? _____ Does any one in your family have this problem or similar? _____

Other doctors seen for this condition? _____

Any home remedies? _____

Other Symptoms:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Tension | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of taste or smell |
| <input type="checkbox"/> Pain between the shoulders | <input type="checkbox"/> Dizziness/loss of balance | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Muscle stiffness | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Buzzing/Ringing in the ears |

Medications (what/how long?) _____

Side effects of medications? _____

Surgeries (what/when?) _____

Side effects of surgeries? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About Your Care

Chiropractic provides three types of care. The first **Initial Intensive Care**, which corrects the most recent layer of spinal and neurological damage. This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care**, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.