

CASE HISTORY

NAME _____ DATE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 H. PHONE(____) _____ W. PHONE(____) _____ DATE OF BIRTH _____ (AGE _____)
 REFERRED BY _____ SOCIAL SECURITY # _____
 OCCUPATION _____ EMPLOYER _____
 MARITAL STATUS: S M D W SPOUSES NAME _____
 SPOUSES OCCUPATION _____ NUMBER OF CHILDREN & AGES _____
 HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____ YES ____ NO

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health. 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

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

PATIENT COMMENT

If answer is YES

CHIROPRACTOR'S

Comments

YES NO 1. YOUR BIRTH PROCESS

_____	_____	Was the delivery long?	_____	_____
_____	_____	Was the delivery difficult?	_____	_____
_____	_____	Forceps?	_____	_____
_____	_____	Cesarean?	_____	_____
_____	_____	Breach?	_____	_____
_____	_____	Home birth?	_____	_____
_____	_____	Hospital birth?	_____	_____
_____	_____	Was labor induced?	_____	_____

2. GROWTH AND DEVELOPMENT (BIRTH THROUGH TEENAGE YEARS)

_____	_____	Were you taught how to care for your spine?	_____	_____
_____	_____	Did you fall out of bed?	_____	_____
_____	_____	Did you have childhood sickness?	_____	_____
_____	_____	Did you have accidents?	_____	_____
_____	_____	Did you have surgery?	_____	_____
_____	_____	Did you experience child abuse?	_____	_____
_____	_____	Did you experience severe spanking?	_____	_____
_____	_____	Did you have your ear/chin pulled?	_____	_____
_____	_____	Chair pulled out when sat down?	_____	_____
_____	_____	Did you fall down stairs?	_____	_____
_____	_____	Were you yanked by your arm?	_____	_____
_____	_____	Did you have other traumas?	_____	_____

YES NO 3. LOSS OF WHOLE BODY HEALTH

_____	_____	Did/ do you drink any alcohol?	_____	_____
_____	_____	Diet (Do you eat healthy foods?)	_____	_____
_____	_____	Have you been in accidents?	_____	_____
_____	_____	Have you had surgery & organs removed/ replaced?	_____	_____
_____	_____	Did/ do you have occupational stress?	_____	_____
_____	_____	Did/ do you have physical stress?	_____	_____
_____	_____	Did/ do you have mental stress?	_____	_____
_____	_____	Do you currently smoke? If yes, how much?	_____	_____
_____	_____	Did/ do you have sports injuries?	_____	_____

PRIMARY REASON FOR CONSULTING OFFICE

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint _____
Pain or problem started on _____
Pains are: _____ SHARP _____ DULL _____ CONSTANT _____ INTERMITTENT
Intensity: _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Frequency: _____ Daily _____ 2-3 times weekly _____ Sporadic
Is this condition worse at certain times of the day? _____ Morning _____ Afternoon _____ Evening _____ During sleep
Is this condition interfering with work? _____ sleep? _____ routine? _____ other? _____
Is this condition getting progressively worse? _____ Other doctors seen for this _____
Are you using any home remedies? _____

To ensure that we assist you achieving your health care goals:

What is your healthcare goal for this problem? _____ Temporary Relief _____ Sustained Relief & Problem correction

OTHER SYMPTOMS:

_____ HEADACHES	_____ PINS & NEEDLES IN LEGS	_____ LOSS OF SMELL
_____ NECK PAIN	_____ NUMBNESS IN FINGERS	_____ LOSS OF TASTE
_____ SLEEPING PROBLEMS	_____ NUMBNESS IN TOES	_____ DIARRHEA
_____ BACK PAIN	_____ SHORTNESS OF BREATH	_____ FEET COLD
_____ NERVOUSNESS	_____ FATIGUE	_____ HANDS COLD
_____ TENSION	_____ DEPRESSION	_____ STOMACH UPSET
_____ IRRITABILITY	_____ LIGHTS BOTHER EYES	_____ CONSTIPATION
_____ CHEST PAINS	_____ LOSS OF MEMORY	_____ COLD SWEATS
_____ DIZZINESS	_____ EARS RING	_____ LOSS OF BALANCE
_____ FACE FLUSHED	_____ FEVER	_____ BUZZING IN EARS
_____ NECK STIFF	_____ FAINTING	_____ OTHER SYMPTOMS

Please list any current medications _____

Please list any known allergies _____

Have you been under medical care recently or for this problem? _____

Have you had surgery? _____ Any side effects from drugs or surgery? _____

Is there a family history of:

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

ABOUT YOUR CARE

Chiropractic provides two types of care. The first is **Relief or Corrective Care**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Following the first phase of care, is **Wellness Care**. It offers a genuine and natural approach maintain optimal physical, mental, and social well being! 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.

Dr. Signature _____ Date _____