Case History

Name____ Date______________________________
Address____ State________________ Zip__________
H. Phone (________)________________________ W. Phone_____________________ Date of Birth__________ Age_________
Referred by____Social Security #___________________________________
Occupation____Employer____
Marital Status S M D W Spouse Name____
Number of Children/Ages___________________________________ Spouses Occupation_________________________________
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 expression. This case history will uncover the layers of damage, especially to your nerve system and spine, that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

Loss of Wellness

Let's begin at your birth, when you may have first damaged your nerve system/spine, lost wellness, and began your journey to your present health.

Please circle for each of the following:			Patient Comment If answer is Yes	Chiropractor's Comments
1.Regarding your Birth Process:				
Was the delivery long/difficult?	Y	N	____________________	____________________
Forceps or extraction used?	Y	N	____________________	____________________
Cesarean/ C-Section?	Y	N	____________________	____________________
Breach/ cephalic?	Y	N	____________________	____________________
Home birth?	Y	N	____________________	____________________
Hospital birth?	Y	N	____________________	____________________
Mother given drugs during delivery?	Y	N	____________________	____________________
Was labor induced?	Y	N	____________________	____________________
2.Regarding your Growth and Development/			____________________	____________________
Childhood:			____________________	____________________
Were you breast fed?	Y	N	____________________	____________________
Were you taught how to care for			____________________	____________________
your spine?	Y	N	____________________	____________________
Childhood illnesses?	Y	N	____________________	____________________
Ear infections/ Colic/ Asthma?	Y	N	____________________	____________________
Attention Deficit?	Y	N	____________________	____________________
Accidents?	Y	N	____________________	____________________
Drugs, including prescription?	Y	N	____________________	____________________
Surgery?	Y	N	____________________	____________________
Did you fall down stairs?	Y	N	____________________	____________________
Chair pulled out when sat down?	Y	N	____________________	____________________
Were you yanked by your arm?	Y	N	____________________	____________________
Did you have other traumas?	Y	N	____________________	____________________
Did you ever break any bones?	Y	N	____________________	____________________
3.Current Health Habits:			____________________	____________________
Did/do you smoke?	Y	N	____________________	____________________
Did/do you drink alcohol?	Y	N	____________________	____________________
Diet, do you eat healthy foods?	Y	N	____________________	____________________
Have you been in accidents/trauma?	Y	N	____________________	____________________
Have you had surgery and organs			____________________	____________________
removed/replaced?	Y	N	____________________	____________________
Drugs, including Prescription?	Y	N	____________________	____________________
Teeth problems?	Y	N	____________________	____________________
Eye problems?	Y	N	____________________	____________________

Hearing problems? Y N ______________________________ ______________________
Exercise regularly? Y N ______________________________ ______________________
Do you sleep well? Y N ______________________________ ______________________
Did/do you have occupational stress? Y N ______________________________ ______________________
Physical stress? Y N ______________________________ ______________________
Emotional/Mental stress? Y N ______________________________ ______________________
Hobbies/Sports injuries? Y N ______________________________ ______________________
Sleeping posture? O side O stomach O back ______________________________ ______________________

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present Complaint/Reason for Seeking Care in this Office:
Major____
Pain or Problem started on____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other______________________
Does this pain shoot, radiate, or travel in your body? Where?______________________________
Are you experiencing numbness or tingling in any area of your body? Where?_______________
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?_______Other?______________________
Is this condition progressively getting worse?____
Please Circle where your at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Other Doctors seen for this condition____
Any home remedies? ____

Please mark any of the following that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

Have you been under drug and medical care?____
What Medications are you taking?____
How long?_________________ Have you had surgery?_________________ What?_________________ When?_________________
What side effects have you experienced from the drugs and surgery?_____________________________
Females Only – Date last Menstrual Period began on_________________________________ Are you possibly Pregnant?___________
Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other__________________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often 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 goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian Signature____Date__________________________