

Case History

Print Name _____	Signature _____	Date _____
Address _____	City _____	State _____ Zip _____
H. Phone (_____) _____	W. Phone (_____) _____	Cell Phone(_____) _____
Date of Birth _____ (Age ____)	Social Security # _____	
Referred By _____	Marital Status	S M D W
Occupation _____	Employer _____	
Spouses Name _____	Spouses Social Security # _____	
Spouses Occupation _____	Number of Children and ages _____	
Have you ever received Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail Address _____	
Insurance Name _____	Insurance Group # _____	
Insurance ID# _____	Insurance Phone number _____	

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, 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. Birth Process		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarian?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/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 delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
		2. Growth and Development		
<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 a headbanger or a rocker?	_____	_____
<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"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____	_____
<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"/>	Spanking (how?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear/chin	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? What? When?	_____	_____

Yes	No	3. Current Health Habits		
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced?	_____	_____
<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"/>	Exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back	_____	_____

Symptoms and Ill Health (Present State of Ill Health)

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

Present Complaint (be brief) _____

Major _____

Pain or Problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fever | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of Balance |
| | | | <input type="checkbox"/> Buzzing in Ears |

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? _____

Are you pregnant? _____ When was the first day of your last menstrual cycle? _____

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"/> |

Chiropractic provides three types of care. The first is **Initial Intensive Care, which** corrects the most recent layer of Spinal and Neurological damage (VSC). 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. 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.