CASE HISTORY

Date:_____

Name:_____ Social Security #:_____ Gender:_____

Date Of Birth:_____ If Referred, By Whom?_____

Address:_____ City:_____ State:___ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell: ( )_____

Occupation: _____ Employer: _____

Marital Status: S M D W Spouse's Name:_____

Spouse's Occupation: _____ # Of Children & Ages_____

Have You Received Chiropractic Care before? 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, that have 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

Your Nerve system is first damaged at Birth, resulting in a decrease of overall wellness and the beginning of your path to ill health. So that is where we will begin our questions, please answer each question to the best of your ability; we understand you may not be able to answer all the questions.

Birth Process

Yes	No	1. Pregnancy *Did Your Mother?*	Patient Comments	Chiropractor's Comment
___	___	Smoke or drink alcohol?	_____	_____
___	___	Have a proper diet?	_____	_____
___	___	Exercise?	_____	_____
___	___	Experience any falls or injuries?	_____	_____
___	___	Experience any physical or mental abuse?	_____	_____
		2. Your Birth Process		
___	___	Was the delivery long?	_____	_____
___	___	Was the delivery difficult?	_____	_____
___	___	Forceps?	_____	_____
___	___	Caesarean?	_____	_____
___	___	Breach/cephalic	_____	_____
___	___	Home birth?	_____	_____
___	___	Hospital birth?	_____	_____
___	___	Mother given drugs during delivery?	_____	_____
____	____	Was labor induced?	_____	_____

Birth – Age 5

Yes	No	3.Growth & Development	Patient Comments	Chiropractor's Comment
___	___	Were you taught how to care for your spine?	_____	_____
___	___	Did you roll out of bed?	_____	_____
___	___	Were you a headbanger/rocker	_____	_____
___	___	Were you breast fed?	_____	_____
___	___	Childhood sicknesses?	_____	_____
___	___	Accidents?	_____	_____
___	___	Surgery?	_____	_____
___	___	Drugs/Medications?	_____	_____
___	___	Did you fall while learning to walk?	_____	_____
___	___	Were you picked on by siblings?	_____	_____
___	___	Child abuse?	_____	_____
___	___	Spanking (how)?	_____	_____
___	___	Pulled ear/chin?	_____	_____
___	___	Other	_____	_____
___	___	Chair pulled when sat down?	_____	_____
___	___	Did you fall down stairs?	_____	_____
___	___	Were you yanked by the arm?	_____	_____
___	___	Did you have other traumas? What? When?	_____	_____

Loss of Whole Body Health

As layers of damage increased, symptoms of illness and random bouts of sickness began to become present.

Age 5 – Present

Yes	No	4.Growth & Development	Patient Comments	Chiropractor's Comment
___	___	Were you taught proper body movement & care?	_____	_____
___	___	Did/do you smoke?	_____	_____
___	___	Did/do you drink alcohol?	_____	_____
___	___	Proper Diet?	_____	_____
___	___	Accidents?	_____	_____
___	___	Have you had surgery/ had organs removed?	_____	_____
___	___	Drugs/Medications?	_____	_____
___	___	Teeth problems?	_____	_____
___	___	Eye problems?	_____	_____
___	___	Hearing problems?	_____	_____
___	___	Exercise regularly?	_____	_____
___	___	Good sleeping habits?	_____	_____
___	___	Occupational stress?	_____	_____
___	___	Physical stress?	_____	_____
___	___	Mental stress?	_____	_____
___	___	Hobbies/sports injuries?	_____	_____
___	___	Other traumas or problems?	_____	_____

Current Symptoms

Years of untreated damage shows up as acute or chronic symptoms. Which brings us to our next section, current symptoms/ present complaint. This section is for you to explain what brings you into our office today, and what type of symptoms you've been experiencing.

Symptoms

____ Headaches
____ Neck Pain
____ Sleeping Problems
____ Back Pain
____ Nervousness
____ Tension
____ Irritability
____ Chest Pain
____ Dizziness
____ Face Flushed
____ Neck Stiff
____ Pins & Needles in legs
____ Pins & Needles in arms
____ Numbness in Fingers
____ Numbness in Toes
____ Shortness of Breath
____ Fatigue
____ Depression
____ Lights Bother Eyes
____ Loss of Memory
____ Ears Ring
____ Fever
____ Fainting
____ Loss of Smell
____ Diarrhea
____ Cold Feet
____ Cold Hands
____ Upset Stomach
____ Constipation
____ Cold Sweats
____ Loss of Balance
____ Buzzing in Ears

Present Complaint

Major Complaint:_____

Pain/Problem Started When?_____

Pains are: ___Sharp ___Dull ___Constant ___Intermittent Is condition getting worse? Yes__ No__

What activities aggravate your condition/problem?_____

Is condition worse during certain time of day? Yes__ No__ If so, when?_____

Is this condition interfering with(circle all that apply): WORK SLEEP ROUTINE OTHER:_____

Other Doctor's seen for this condition:_____

Any Home Remedies:_____

Have you been under drug and medical care? Yes___ No___
If yes, please explain:_____

What medications are you taking?_____

Have you had surgery? Yes__ No__ For What?_____ When?_____

What side effects (if any) did you experience from the drugs and surgery?_____
_____

Family History

Father's Side
Heart Disease ___ Cancer___
Arthritis___ Diabetes___
Other:_____

Mother's Side
Heart Disease___ Cancer___
Arthritis___ Diabetes___
Other:_____