CASE HISTORY

Date_____ Title: Mr. Mrs. Miss Ms. Dr. (circle one)
Last Name _____First Name _____ Middle Initial _____
Address _____City _____ State _____Zip _____
Home Phone # _____Work Phone # _____Cell Phone # _____
E-mail Address _____
Social Security # _____ Age _____ Date of Birth _____ Sex: Male or Female
Height _____ Weight _____ Status: Married, Single, Widowed, Divorced # of Children_____
Spouse's Name _____ Occupation _____ Employer _____
Your Occupation _____ Employer _____
Employers Address _____ City _____ State _____ Zip _____
Nearest Relative Not Living With You _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Person Responsible For This Account _____
How were you referred to this office? Friend/Relative, Name _____
Yellow Pages Newspaper TV Direct Mail Exam Card
Coupon Radio Courtesy Call Other_____
Have you seen a Chiropractor in the Past? ( ) Yes ( ) No Name _____
What type of care best fits your needs? ( ) Treatment Only ( ) Prevention ( ) Family Health
( ) Maintaining Health
Do you have general Health Insurance that you would like to utilize for your 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, 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.

BIRTH PROCESS

Yes No
( ) ( ) Were there any unusual circumstances during your mother's pregnancy with you? Explain_____
( ) ( ) Did your mother smoke or use alcohol during pregnancy?
( ) ( ) Did your mother use prescribed, over the counter, or other drugs during pregnancy?
( ) ( ) Was an ultrasound done? Why? _____
( ) ( ) Were there any unusual circumstances during your birth? Explain _____
( ) ( ) Was the delivery long or difficult?
( ) ( ) Were Forceps or Vacuum extraction used? Caesarean or Breach? (Circle all that apply)
( ) ( ) Hospital Birth, Birthing Center, or Home Birth? (please circle one)
( ) ( ) Was labor induced?
( ) ( ) Mother given drugs during delivery?

GROWTH & DEVELOPMENT

Yes No
( ) ( ) Were you breast fed or bottle fed? (please circle one)
( ) ( ) Please circle the childhood illnesses you've had: Measles, Mumps, Chicken Pox, Rubella,
Rheumatic Fever, Ear Infections, Allergies, Asthma
( ) ( ) Accidents / Injuries? Explain _____
( ) ( ) Surgery? Explain _____
( ) ( ) Did you take any drugs? Prescription, Non-Prescription, Homeopathic, Other (please circle all that apply)
( ) ( ) Were you taught how to care for your spine?
( ) ( ) Did you fall out of bed?
( ) ( ) Did you experience child abuse? Mental, Physical, Sexual (please circle all that apply)
( ) ( ) Chair pulled out when you sat?
( ) ( ) Did you fall down stairs?
( ) ( ) Did you have other traumas? What? When? _____

CURRENT HEALTH HABBITS

Yes No

( ) ( ) Did/do you smoke? How much? _____

( ) ( ) Did/do you drink alcohol? How much? _____

( ) ( ) Do you eat/drink; Soda Coffee Sugar/Sweets Milk or Dairy Red Meat Poultry Fish Vegetables/Legumes

( ) ( ) Have you been in accidents? Automobile, Work Related, Home, Other _____

( ) ( ) Have you had surgery and/or organs removed/replaced? Explain _____

( ) ( ) Are you taking any drugs? Prescription, Over the Counter, Other _____

( ) ( ) Problems with; Teeth Eyes Hearing (Circle all that apply)

( ) ( ) Do you exercise regularly? How often? _____ What type? _____

Sleeping Posture; Side Stomach Back (please circle all that apply)

SYMPTOMS AND ILL HEALTH (Present State of Ill Health): Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present/Primary Complaint _____

Other Complaints _____

Pain or Problem started on _____

Pain is: Sharp Dull Achy Stiff Throbbing Constant Comes & goes Daily

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 Daily Routine Other _____

Is this condition getting; Worse Better Staying the Same

Other Doctors seen for this condition _____

Other remedies tried: Aspirin Muscle Relaxers Pain Medication Cortisone

Result _____

What is your major contributor of stress? Physical Mental Job

What drugs are currently taking? _____

How long have you been taking them? _____

Have you had surgery for this condition? _____ What kind? _____ When? _____

What side effects have you experienced from the drugs and/or surgery? _____

OTHER SYMPTOMS

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

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	( )	( )	( )	( )	
Mother's side	( )	( )	( )	( )	

CHIROPRACTIC HAS ONLY ONE GOAL: To locate, analyze, and correct spinal interferences to the nervous system. We **do not** diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We provide no cure from any condition(s) or disease(s).

Signature: _____ Date:_____