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## 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
<b>YES NO 1. BIRTH PROCESS</b>		
_____ _____ Did your mother experience any falls & injury's during pregnancy?	_____	_____
_____ _____ Was the delivery long?	_____	_____
_____ _____ Was the delivery difficult?	_____	_____
_____ _____ Forceps?	_____	_____
_____ _____ Cesarean?	_____	_____
_____ _____ Breach?	_____	_____
_____ _____ Home birth?	_____	_____
_____ _____ Hospital birth?	_____	_____
_____ _____ Mother given drugs during delivery?	_____	_____
_____ _____ 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 take drugs?	_____	_____
_____ _____ 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 smoke?	_____	_____
_____	_____	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 take drugs prescriptive or non-prescriptive?	_____	_____
_____	_____	Did/ do you have occupational stress?	_____	_____
_____	_____	Did/ do you have physical stress?	_____	_____
_____	_____	Did/ do you have mental stress?	_____	_____
_____	_____	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? \_\_\_\_\_

**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

Have you been under medical care recently or for this problem? \_\_\_\_\_  
 Have you been taking prescriptive or non-prescriptive drugs \_\_\_\_\_  
 Have you had surgery? \_\_\_\_\_ Any side effects from drugs or surgery? \_\_\_\_\_  
 Is there a family history of:

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Father's side	_____	_____	_____	_____	_____
Mother's side	_____	_____	_____	_____	_____

**ABOUT YOUR CARE**

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. 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 health goals.

Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_