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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

This case history starts from the beginning of your life up through present day. These injuries and misalignments may or may not have been painful. The longer they have been present the more time they have to grow in wrong.

| YES | NO | 1. YOUR BIRTH PROCESS | PATIENT COMMENT If answer is YES | CHIROPRACTOR'S Comments |
|---|---|---|---|---|
| ______ | ______ | Was the delivery long? | ______________________ | ________________ |
| ______ | ______ | Was the delivery difficult? | ______________________ | ________________ |
| ______ | ______ | Forceps? | ______________________ | ________________ |
| ______ | ______ | Cesarean? | ______________________ | ________________ |
| ______ | ______ | Breach? | ______________________ | ________________ |
| ______ | ______ | Home birth? | ______________________ | ________________ |
| ______ | ______ | Hospital birth? | ______________________ | ________________ |
| ______ | ______ | 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 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**

| YES | NO | | | |
|---|---|---|---|---|
| ______ | ______ | Did/ do you drink any alcohol? | ____________________________ | ____________________ |
| ______ | ______ | Diet (Do you eat healthy foods?) | ____________________________ | ____________________ |
| ______ | ______ | Have you been in any auto accidents? | ____________________________ | ____________________ |
| ______ | ______ | Have you had surgery & organs removed/ replaced? | ____________________________ | ____________________ |
| ______ | ______ | Did/ do you have occupational stress? | ____________________________ | ____________________ |
| ______ | ______ | Did/ do you have physical stress? | ____________________________ | ____________________ |
| ______ | ______ | Did/ do you have mental stress? | ____________________________ | ____________________ |
| ______ | ______ | Do you currently smoke? If yes, how much? | ____________________________ | ____________________ |
| ______ | ______ | 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 ______Sporatic
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 remedys?__________________________________________________________

To ensure that we assist you achieving your health care goals:
What is your healthcare goal for this problem? ___Temporary Relief ___Sustained Relief & Problem correction

**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 |

Please list any current medications_____________________________________________________
Please list any known allergies_________________________________________________________
Have you been under medical care recently or for this problem?______________________________
Have you had surgery?_____________Any side effects from drugs or surgery?___________________
Is there a family history of:

| | HEART DISEASE | ARTHRITIS | CANCER | DIABETES | OTHER |
|---|---|---|---|---|---|
| Fathers side | ______ | ______ | ______ | ______ | ______ |
| Mothers side | ______ | ______ | ______ | ______ | ______ |

# ABOUT YOUR CARE

Chiropractic provides two types of care. The first is **Relief**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Following the first phase of care, is **Wellness and Corrective Care** . It offers a genuine and natural approach maintain optimal physical, mental, and social well being! 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____________________