Estero Family Chiropractic
Everyone needs a chiropractor on their health care team

21740 S. Tamiami Trail #103, Estero FL, 33928

Esterofamilychiropractic.com
Ph: 239-676-9116
Fax: 239-221-3959

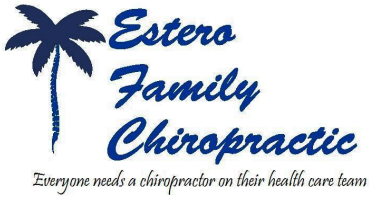
Case History

Name:_____Date:_____
Date of Birth:_____Age:_____Gender: _____
Address:_____
City:_____State:_____ZIP:_____
Phone:_____Email:_____
Occupation: _____ Employer: _____
Marital Status: Single Married Divorced Widow
If applicable: Spouse's Name:_____Number of Childldren:_____
Emergency Contact:_____Phone:_____
Referred by or how you found our office:_____
If you have had chiropractic care in the past, approximately how long since your last visit? _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your body affecting your health and ability to heal. This case history will uncover those injuries. 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. Following your exam, your chiropractor will outline a course of care to correct these injuries and misalignments which will optimize your ability to heal and symptomatically feel better.

YES	NO		COMMENTS
_____	_____	Are you aware of any injuries during your birth process?	_____
_____	_____	Have you ever been diagnosed with Torticollis?	_____
_____	_____	Did/ do you drink any alcohol?	_____
_____	_____	Diet (Do you eat healthy foods?)	_____
_____	_____	Do you currently smoke? If yes, how much?	_____
_____	_____	Have you broken any bones?	_____
_____	_____	Did you have surgical alterations, ie joint replacements?	_____
_____	_____	Have you been in any auto accidents? If so when	_____
_____	_____	Have you had surgery & organs removed?	_____
_____	_____	Do you have any spinal fusions? If so, where?	_____
_____	_____	Any cosmetic surgeries that would affect treatments?	_____
_____	_____	Did/ do you have scoliosis?	_____
_____	_____	Did/ do you have physical stress?	_____
_____	_____	Did/ do you have mental stress?	_____
_____	_____	Did/ do you have sports injuries?	_____
_____	_____	Do you sit for work? If so, about how long?	_____
_____	_____	Does your job require you to bend and twist?	_____
_____	_____	Does your job require you to stand? If so, how long?	_____
_____	_____	Have you ever had a pinched nerve or Sciatica?	_____
_____	_____	Have you ever been diagnosed with a bulging disc?	_____



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PRIMARY REASON FOR CONSULTING OFFICE

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?_____ recreation?_____
self care_____walking_____sitting_____standing_____other?_____
Is this condition getting progressively worse? Yes No Same Unsure
Other doctors seen for this:_____
Are you using any home remedies?_____
Secondary issues of concern or comments:_____

We strive to help you achieve your health care related goals. Are you interested in preventative related care for this condition to help ensure it does not get worse? Yes____ No____

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
_____SLURRED SPEECH	_____HISTORY OF STROKES	_____ANEURYSMS
_____DIZZINESS	_____EARS RING	_____LOSS OF BALANCE
_____FACE FLUSHED	_____FEVER	_____BUZZING IN EARS
_____NECK STIFF	_____FAINTING	_____OSTEOPOROSIS/OSTEOPENIA
_____MUSCLE SPASMS	_____DOUBLE VISION	_____WEAKNESS IN ARMS/LEGS

Please list any current medications _____
_____
Please list any known allergies_____

Is there a family history of?	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	Autoimmune
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

ABOUT YOUR CARE: Chiropractic provides two types of care. The first is **Relief and Stabilization**. This care usually reduces or eliminates the symptoms. Following the first phase of care, is **Preventative and Corrective Care**. This type of care helps maintain the progress you've made during the Relief phase of care while working to further correct structural misalignments. These options will be explained at your report of findings. We look forward to helping you achieve your health goals.

Patient Signature:_____ Date: _____