

Case History

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 H. Phone (_____) _____ W. Phone _____ Date of Birth _____ (Age _____)
 Referred by _____
 Occupation _____ Employer _____
 Marital Status S M D W Spouse's Name _____
 Spouse's Occupation _____ Number of Children and Ages _____
 Have you ever received Chiropractic Care? Yes No
 Social Security # _____

Loss of Whole Body (Age 5 - Present)

As you increased the layers of damage you probably began to experience symptoms and random bouts of sickness.

Yes	No	(Age 5 - present)	Patient Comment if answer is Yes	Chiropractor's Comments
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught proper body movement and care?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (Prescriptive or non-prescriptive)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems	_____	_____
		Sleeping posture <input type="checkbox"/> Side <input type="checkbox"/> Stomach <input type="checkbox"/> Back	_____	_____

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present Complaint (be brief)

Major _____

Pain or Problem started on _____

Pains are: Sharp Dull Constant Intermittent

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? _____ Routine? _____ Other? _____

Is condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ears |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

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

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Insurance Information

Have you been in an accident? Yes No
 Work Auto Other Date _____ Nature of accident _____

Did you feel a popping or tearing noise in your neck or back? _____ Explain _____

Did you require post-accident hospitalization? _____

Where? _____ When? _____ Were X-rays taken? _____

Have you lost days at work? _____ Date _____

Is insurance involved? _____ Which company? _____ Address _____

Attorney's name, if any _____ Claim # _____

Comments (Office use only) _____

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.