

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 have 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.

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.

Loss of Wellness (Birth - Age 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes	No	(Birth -- Age 5)	Patient Comment (if answer is Yes)	Chiropractor's Comments
<input type="checkbox"/>	<input type="checkbox"/>	1. Pregnancy		
		<i>Did your mother:</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Smoke or drink alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have a proper diet?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise through her pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any falls and injuries during pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any physical and/or mental abuse?	_____	_____
		2. Birth Process		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
		3. Growth and Development		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you roll out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you a headbanger or rocker?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear/chin	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? What? When?	_____	_____

Loss of Whole Body Health (Age 5 – present)

As layers of damage increased, 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 ever 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	_____	_____

Symptoms and Ill Health (Present State of Ill Health)

Years of untreated damage showed up as acute or chronic symptoms.

Other Symptoms:

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

PRESENT COMPLAINT

Major complaint: _____

Pain or Problem started when: _____

Pains are: Sharp Dull Constant Intermittent Is condition getting progressively worse? Yes No

What activities aggravate your condition/pain? _____

Is condition worse during certain times of the day? Yes No If so, when? _____

Is this condition interfering with (circle those that apply): Work? Sleep? Routine? Other: _____

Other doctors seen for this condition: _____

Any home remedies? _____

Symptoms and Ill Health (cont'd)

Have you been under drug and medical care? Yes No

If yes, please explain: _____

What medications are you taking? _____ How long? _____

Have you had surgery? Yes No

FAMILY HISTORY

For what? _____

Father's Side

Mother's Side

When? _____

Heart Disease

Heart Disease

What side effects (if any) did you experience from the drugs and surgery?

Arthritis

Arthritis

Cancer

Cancer

Diabetes

Diabetes

Other, _____ Other: _____

Patient Information

Name: _____ Social Security #: _____ Date: _____

Gender: Male Female Date of Birth: _____ (Age: _____) If you were referred, by whom? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Occupation: _____ Employer: _____

Marital Status: S M D W Spouse's Name and Occupation: _____

Number of Children and Ages: _____

Have you ever received Chiropractic care? Yes No

Have you ever been in an accident? Yes No Work Auto Other: _____

Nature of Accident: _____ When? _____

Did you feel a popping or tearing noise in your neck or back? Yes No

Did you require post-accident hospitalization? Yes No

Where? _____ When? _____ Were X-rays taken? Yes No

Did you lose days at work as a result? Yes No How many? _____

Is insurance involved? Yes No _____ Which company? _____

Attorney's name: n/a _____ Claim #: _____

Comments (office use only): _____