



Chiropractic and Wellness Center
"Improving Health and Enriching Lives"

Case History

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.

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. Next begins Reconstructive Care which corrects the years of damage that have 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.

If answer is YES, please describe in the space provided.

YES NO

1. PREGNANCY

_____ Did your mother experience any falls & injury's during pregnancy? _____

2. BIRTH PROCESS

_____ Was the delivery long? _____

_____ Was the delivery difficult? _____

_____ Forceps? _____

_____ Cesarean? _____

_____ Breach? _____

_____ Home birth? _____

_____ Hospital birth? _____

_____ Mother given drugs during delivery? _____

_____ Was labor induced? _____

3. GROWTH AND DEVELOPMENT

_____ 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? _____

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

_____ 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? _____

Symptoms and Ill Health (Present State of Ill Health)

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

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

PRESENT COMPLAINT:

Major 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?

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? _____

FAMILY HISTORY:

Fathers Side:	Mothers Side:
Heart Disease _____	Heart Disease _____
Cancer _____	Cancer _____
Diabetes _____	Diabetes _____
Arthritis _____	Arthritis _____
Other _____	Other _____

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
H. PHONE(____) _____ W. PHONE(____) _____
DATE OF BIRTH _____ (AGE _____)
REFERRED BY _____
SOCIAL SECURITY # _____
OCCUPATION _____ EMPLOYER _____
MARITAL STATUS (circle one): Single Married Divorced Widowed
SPOUSES NAME _____
SPOUSES OCCUPATION _____
NUMBER OF CHILDREN & AGES _____
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ___ YES ___ NO

Dr. Signature _____ Date _____