

# CASE HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ If Referred, By Whom? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: S M D W Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ # Of Children & Ages \_\_\_\_\_

Have You Received Chiropractic Care before? Yes \_\_\_\_\_ No \_\_\_\_\_

## 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.

### LOSS OF WELLNESS

Your Nerve system is first damaged at Birth, resulting in a decrease of overall wellness and the beginning of your path to ill health. So that is where we will begin our questions, please answer each question to the best of your ability; we understand you may not be able to answer all the questions.

#### Birth Process

Yes	No	1. Pregnancy <i>Did Your Mother?</i>	Patient Comments	Chiropractor's Comment
___	___	Smoke or drink alcohol?	_____	_____
___	___	Have a proper diet?	_____	_____
___	___	Exercise?	_____	_____
___	___	Experience any falls or injuries?	_____	_____
___	___	Experience any physical or mental abuse?	_____	_____
<b>2. Your Birth Process</b>				
___	___	Was the delivery long?	_____	_____
___	___	Was the delivery difficult?	_____	_____
___	___	Forceps?	_____	_____
___	___	Caesarean?	_____	_____
___	___	Breach/cephalic	_____	_____
___	___	Home birth?	_____	_____
___	___	Hospital birth?	_____	_____
___	___	Mother given drugs during delivery?	_____	_____
___	___	Was labor induced?	_____	_____

**Birth – Age 5**

<b>Yes</b>	<b>No</b>	<b>3.Growth &amp; Development</b>	<b>Patient Comments</b>	<b>Chiropractor's Comment</b>
___	___	Were you taught how to care for your spine?	_____	_____
___	___	Did you roll out of bed?	_____	_____
___	___	Were you a headbanger/rocker	_____	_____
___	___	Were you breast fed?	_____	_____
___	___	Childhood sicknesses?	_____	_____
___	___	Accidents?	_____	_____
___	___	Surgery?	_____	_____
___	___	Drugs/Medications?	_____	_____
___	___	Did you fall while learning to walk?	_____	_____
___	___	Were you picked on by siblings?	_____	_____
___	___	Child abuse?	_____	_____
___	___	Spanking (how)?	_____	_____
___	___	Pulled ear/chin?	_____	_____
___	___	Other	_____	_____
___	___	Chair pulled when sat down?	_____	_____
___	___	Did you fall down stairs?	_____	_____
___	___	Were you yanked by the arm?	_____	_____
___	___	Did you have other traumas? What? When?	_____	_____

**Loss of Whole Body Health**

**As layers of damage increased, symptoms of illness and random bouts of sickness began to become present.**

**Age 5 – Present**

<b>Yes</b>	<b>No</b>	<b>4.Growth &amp; Development</b>	<b>Patient Comments</b>	<b>Chiropractor's Comment</b>
___	___	Were you taught proper body movement & care?	_____	_____
___	___	Did/do you smoke?	_____	_____
___	___	Did/do you drink alcohol?	_____	_____
___	___	Proper Diet?	_____	_____
___	___	Accidents?	_____	_____
___	___	Have you had surgery/had organs removed?	_____	_____
___	___	Drugs/Medications?	_____	_____
___	___	Teeth problems?	_____	_____
___	___	Eye problems?	_____	_____
___	___	Hearing problems?	_____	_____
___	___	Exercise regularly?	_____	_____
___	___	Good sleeping habits?	_____	_____
___	___	Occupational stress?	_____	_____
___	___	Physical stress?	_____	_____
___	___	Mental stress?	_____	_____
___	___	Hobbies/sports injuries?	_____	_____
___	___	Other traumas or problems?	_____	_____

## **Current Symptoms**

**Years of untreated damage shows up as acute or chronic symptoms. Which brings us to our next section, current symptoms/ present complaint. This section is for you to explain what brings you into our office today, and what type of symptoms you've been experiencing.**

### Symptoms

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

### Present Complaint

Major Complaint: \_\_\_\_\_

Pain/Problem Started When? \_\_\_\_\_

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

What activities aggravate your condition/problem? \_\_\_\_\_

Is condition worse during certain time of day? Yes  No  If so, when? \_\_\_\_\_

Is this condition interfering with(circle all that apply): WORK SLEEP ROUTINE OTHER: \_\_\_\_\_

Other Doctor's seen for this condition: \_\_\_\_\_

Any Home Remedies: \_\_\_\_\_

Have you been under drug and medical care? Yes  No

If yes, please explain: \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

Have you had surgery? Yes  No  For What? \_\_\_\_\_ When? \_\_\_\_\_

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

### Family History

#### Father's Side

Heart Disease  Cancer   
Arthritis  Diabetes   
Other: \_\_\_\_\_

#### Mother's Side

Heart Disease  Cancer   
Arthritis  Diabetes   
Other: \_\_\_\_\_

