CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Name _____ Date_____

Have you ever received Chiropractic Care? ☐No ☐Yes If Yes, Reason & When _____

Main reason for being seen today, Major Complaint: _____

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 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

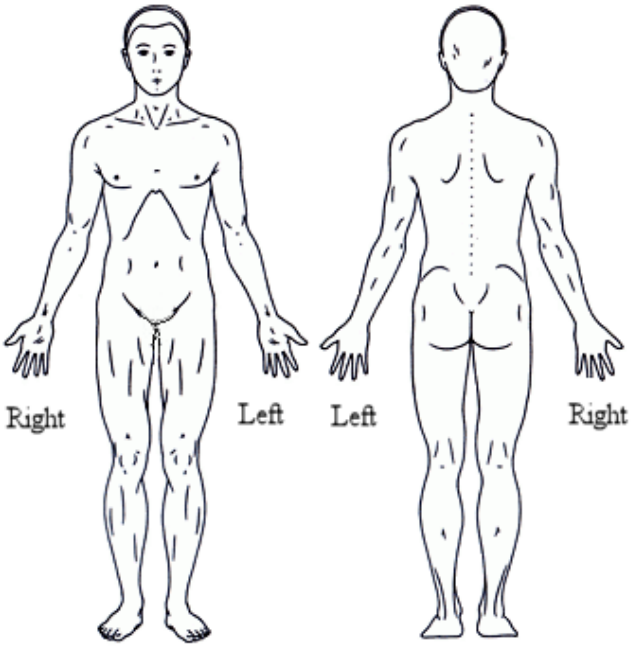
Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes No	1. Birth Process	Patient's Comments (if answer if Yes)		Chiropractor's Comments
☐ ☐	Was the delivery difficult?			
☐ ☐	Forceps			
☐ ☐	Caesarean?			
☐ ☐	Breach/cephalic?			
☐ ☐	Mother given drugs during delivery?			
☐ ☐	Was labor induced?			
	2. Growth and Development			
☐ ☐	Were you taught how to care for your spine?			
☐ ☐	Did you fall out of bed?			
☐ ☐	Were you a headbanger or rocker?			
☐ ☐	Accidents?			
☐ ☐	Surgery?			
☐ ☐	Did you fall while learning to walk?			
☐ ☐	Were you picked up by siblings?			
☐ ☐	Chair pulled out when sat down?			
☐ ☐	Did you fall down stairs?			
☐ ☐	Were you yanked by your arm?			
☐ ☐	Did you have other traumas? What? When?			
	3. Current Health Habits			
☐ ☐	Did/do you smoke?			
☐ ☐	Did/do you drink alcohol?			
☐ ☐	Diet (do you eat healthy foods?)			
☐ ☐	Have you been in accidents?			
☐ ☐	Have you had surgery or organs removed/replaced?			
☐ ☐	Drugs? (Prescriptive or non-prescriptive)			
☐ ☐	Teeth problems?			
☐ ☐	Eye problems?			
☐ ☐	Hearing problems?			
☐ ☐	Exercise regularly?			
☐ ☐	Did/do you have occupational stress?			
☐ ☐	Physical stress?			
☐ ☐	Mental stress?			
☐ ☐	Hobbies / Sports injuries?			
☐ ☐	Sleeping posture: □side □stomach □back			

Symptons and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms. (Be brief)

Please mark recent problem areas on the illustrations below and answer the following questions:



Numbness = = =
Dull Ache OOO
Burning XXX
Sharp/Stabbing / / /
Pins, Needles + + +
Other _____ ^ ^ ^

Present Major Complaint:
_____
Have you experienced anything like this before? □Yes □No
Is there a family history of similar issues? □Yes □No

When did the problem begin? (Most recent episode):
_____

Can you think of anything that caused the problem?
_____

My current problem can be described as (check all that apply):
□Electric □Sharp □Stabbing □Knife-like □Piercing □Shooting
□Achy □Griping □Heavy □Cramp-like □Burning □Deep
□Superficial □Stiffness(AM >1-2 hours or PM or Both)
□Spasm □Tearing □N/A

Please circle your degree of pain on the below scale of 0 to 10:
(at rest)No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain (with activity) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain
What time of day is your current problem worse? □Morning □Afternoon □Evening □Middle of night □As day progresses □N/A
Are the symptoms □constant □come and go How long does the problem last?_____
Do the symptoms stay local to the area or do they travel someplace else? _____
Activities or movements that are difficult/painful to perform: □Sitting □Standing □Walking □Bending □ Lying Down
What other activities aggravate your condition? _____
What activities lessen you condition? _____
Does it interfere with your: □Work □Sleep □Daily Routine □Recreation
My current problem seems to be:
□Getting better □Staying the same □Getting worse □N/A Explain:_____

What treatment have you already received for your condition?
□Medications □Surgery □Physical Therapy □Chiropractic Care □None
Name of other doctor(s) who have treated you for this condition? _____
List any diagnosis and type of treatment:_____
Were you satisfied with the results of your treatment? Yes No
Any home remedies? _____

Other Symptoms?

☐ Headaches	☐ Pins & Needles in	☐ Face Flushed	☐ Diarrhea
☐ Neck Pain	☐ Pins & Needles in	☐ Neck Stiff	☐ Feet Cold
☐ Sleeping Problems	☐ Numbness in Fingers	☐ Loss of Memory	☐ Hands Cold
☐ Back Pain	☐ Numbness in Toes	☐ Ears Ring	☐ Stomach Upset
☐ Nervousness	☐ Shortness of Breath	☐ Fever	☐ Constipation
☐ Tension	☐ Fatigue	☐ Fainting	☐ Cold Sweats
☐ Irritability	☐ Depression	☐ Loss of Smell	☐ Loss of Balance
☐ Chest Pains	☐ Light Bother Eyes	☐ Loss of Taste	☐ Buzzing in Ears
☐ Dizziness	☐ _____	☐ _____	☐ _____

Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting				
Rising out of chair				
Standing				
Walking				
Laying down				
Bending over				
Climbing stairs				
Using a computer				
Getting in/out of car				
Driving a car				
Looking over shoulder				
Caring for family				

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Love life				
Getting to sleep				
Staying asleep				
Concentrating				
Exercising				
Yard work				

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: (check all that apply)

	Heart Disease	*Arthritis*	*Cancer*	*Diabetes*	*Other*
Father's Side:	☐	☐	☐	☐	☐ _____
Mother's Side:	☐	☐	☐	☐	☐ _____

About Your Care

Chiropractic provides three type of care. The first is ***Initial Intensive Care***, which corrects the most recent layer of Spinal and Neurological damage (VCS). 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. Any finally, Chiropractic Care 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.

What phase of care do you want to achieve for your current condition?
□ ***Initial Intensive Care*** I want to reduce the current amount of pain/discomfort for the least amount of my time and money. I also understand that my condition may return in the future.
□ ***Reconstructive Care*** I want to correct any underlying spinal injury as well as strengthening the muscles, improve spinal function and provide more complete or optimum healing of tissues and organ systems.
□**Wellness Care** I want to maintain my improved health and spinal function, and prevent the return of the original condition once spinal correction has been attained and catch small problems before they become serious.

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Signature_____ Date_____