

Date \_\_\_\_\_

## Your Health History

Name \_\_\_\_\_ Email: \_\_\_\_\_  
 Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Ph: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital Status   S   M   D   W   Spouse Name \_\_\_\_\_ # of Children/Ages \_\_\_\_\_  
 Have you ever received Chiropractic Care? Yes   No   How recently: \_\_\_\_\_

**About Your Health**

The human body is designed to be healthy. Throughout life, events or injuries occur which damage your health expression by affecting your nervous systems ability to maintain health. This case history will uncover the damage, especially to your nerve system and spine, which can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct the Subluxations or misalignments in your spine that help you recover your inborn/innate health potential. Your body is meant to be healthy.

**Loss of Wellness**

Let's begin at your birth, when you may have first damaged your nerve system/spine, lost wellness, and began your journey to your present health.

**Please circle for each of the following:**

Patient's Comments	<i>Chiropractor's Comment (If answer is Yes)</i>
<b>1.Regarding your Growth and Development/ Childhood:</b>	
Childhood illnesses?	Y   N   _____
Ear infections/ Colic/ Asthma?	Y   N   _____
Attention Deficit?	Y   N   _____
Accidents?	Y   N   _____
Drugs, including prescription?	Y   N   _____
Surgery?	Y   N   _____
Did you suffer any slips/falls?	Y   N   _____
Did you have other traumas?	Y   N   _____
Did you have any car accidents?	Y   N   _____
Did you ever break any bones?	Y   N   _____
<b>2.Current Health Habits:</b>	
Did/do you smoke or drink alcohol?	Y   N   _____
Diet, do you eat healthy foods?	Y   N   _____
Have you been in accidents/trauma?	Y   N   _____
Have you had surgery (where)?	Y   N   (remark below)
Drugs, including Prescription?	Y   N   (list below)
Teeth problems?	Y   N   _____
Eye or Hearing problems?	Y   N   _____
Exercise regularly?	Y   N   _____
Emotional/Mental stress?	Y   N   _____
Hobbies/Sports injuries?	Y   N   _____
Do you sleep well?	Y   N   _____
Sleeping posture? <input type="radio"/> side <input type="radio"/> stomach <input type="radio"/> back	_____

**Symptoms and Present State of Health**

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms. Misalignments / Subluxations of the spine when present over time may create symptoms.

**Present Complaint/Reason for Seeking Care in this Office:**

Major \_\_\_\_\_  
 Pain or Problem started on: \_\_\_\_\_  
 Pains are:     Sharp             Dull/ Ache     Constant     Intermittent     Other \_\_\_\_\_  
 Does this pain shoot, radiate, or travel in your body? Y   N Where? \_\_\_\_\_  
 Are you experiencing numbness or tingling in any area of your body? Where? \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_  
 What activities lessen your condition/pain? \_\_\_\_\_  
 Is this condition worse during certain times of the day? \_\_\_\_\_  
 Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_  
 Is this condition progressively getting worse? \_\_\_\_\_  
 Please Circle where you're at: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)  
 Other Doctors seen for this condition \_\_\_\_\_  
 Any home remedies? \_\_\_\_\_

Please mark any of the following that you have now or have experienced:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pain in Hands or Arms     | <input type="checkbox"/> Poor Posture           |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack           |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Pain in Legs or Feet      | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Numbness in Legs or Feet  | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Depression                | <input type="checkbox"/> Chest Pains            |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Lights Bother Eyes        | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Loss of Memory            | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain             | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Sinus                     | <input type="checkbox"/> Stomach Upset          |
| <input type="checkbox"/> Joint Swelling         | <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Menstrual Cramps       |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Weight Loss            |
| <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Loss of Smell or Taste |

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? \_\_\_\_\_

Females Only – Date last Menstrual Period began on \_\_\_\_\_ Are you possibly Pregnant? Y N

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"/>

**Are you interested in:    Temporary Pain Relief                      Total Correction of the Problem(s)**

**How would you rate your commitment to getting this problem corrected?**

Low Commitment            1 2 3 4 5 6 7 8 9 10            High Commitment

**About Your Care**

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage (**VSC: Vertebral Subluxation Complex**). This care often reduces or eliminates the symptoms. Then begins **Corrective 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 goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statutes, to provide me with chiropractic care.

Patient or Guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_