www.abcchiropractic.com

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.

LOSS OF WELLNESS (Birth – Age 5)

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

PATIENT COMMENT
If answer is YES Comments

YES NO 1. PREGNANCY

_____ _____ **Did your mother experience any falls & injuries 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?** _____

YES NO 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.

_____ _____ **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:	**Heart Disease**	_____	**Mothers Side:**	**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: S M D W SPOUSE'S NAME_____

SPOUSE'S OCCUPATION_____

NUMBER OF CHILDREN & AGES_____

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____YES ____NO

In the event of an emergency, who may we contact **(other than spouse)**?

Name, address, and phone:

_____

_____

E-mail address:

_____@_____

*If you cannot keep your appointment for any reason, it is **imperative that you contact this office**. Failure to contact the office may result in a broken appointment fee. No one can afford wasted time. A broken appointment affects three people; you, the doctor, and another patient who needs the time. Thank you.*

Fees are payable at the time services are rendered, unless other arrangements have been made in advance. X-rays remain the property of this office.

Signature: _____

Date: _____

Dr. Signature_____**Date**_____