Case History

Name: _____ Date: _____

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.

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 usually reduces or eliminates the symptoms. Then begins **Reconstructive 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 health goals.

Loss of Wellness (Birth - Age 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and journey to ill health starts.

Yes	No	**Your Mother's Pregnancy**	**Patient Comments**	**Chiropractor Comments**
		Did your mother...		
☐	☐	1] Exercise through her pregnancy?	1]_____	_____
☐	☐	2] Smoke or drink alcohol?	2]_____	_____
☐	☐	3] Have a proper diet?	3]_____	_____
☐	☐	4] Experience any physical and/or mental abuse?	4]_____	_____
☐	☐	5] Experience any falls/injuries during pregnancy?	5]_____	_____

Yes	No	**Your Birth Process**		
☐	☐	1] Was the delivery long?	1]_____	_____
☐	☐	2] Was the delivery difficult?	2]_____	_____
☐	☐	3] Forceps?	3]_____	_____
☐	☐	4] Caesarean?	4]_____	_____
☐	☐	5] Breach/cephalic?	5]_____	_____
☐	☐	6] Home birth?	6]_____	_____
☐	☐	7] Hospital birth?	7]_____	_____
☐	☐	8] Mother given drugs during delivery?	8]_____	_____
☐	☐	9] Was labor induced?	9]_____	_____

Yes	No	**Growth and Development (up to age 5)**		
☐	☐	1] Were you taught how to care for your spine?	1]_____	_____
☐	☐	2] Did you fall out of bed?	2]_____	_____
☐	☐	3] Were you a headbanger or rocker?	3]_____	_____
☐	☐	4] Were you breast fed?	4]_____	_____
☐	☐	5] Childhood sicknesses?	5]_____	_____
☐	☐	6] Accidents?	6]_____	_____
☐	☐	7] Surgery?	7]_____	_____
☐	☐	8] Drugs?	8]_____	_____
☐	☐	9] Did you fall while learning to walk?	9]_____	_____
☐	☐	10] Were you picked on by siblings?	10]_____	_____
☐	☐	11] Child abuse?	11]_____	_____
☐	☐	12] Spanking (how)?	12]_____	_____
☐	☐	13] Pulled ear/chin?	13]_____	_____
☐	☐	14] Other?	14]_____	_____
☐	☐	15] Chair pulled out when sat down?	15]_____	_____
☐	☐	16] Did you fall down the stairs?	16]_____	_____
☐	☐	17] Were you yanked by your arm?	17]_____	_____
☐	☐	18] Did you have other traumas? What? When?	18]_____	_____

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Loss of Whole Body Health (Age 5 - Present)

At birth, when your nerve system is first damaged, your wellness begins to decrease and journey to ill health starts.

Yes	No	(Age 5 - Present)	Patient Comments	Chiropractor Comments
☐	☐	1]Were you taught proper body movement & care?	1]_____	_____
☐	☐	2] Have you seen a chiropractor before?	2]_____	_____
☐	☐	3] Did/do you smoke?	3]_____	_____
☐	☐	4] Did/do you drink any alcohol?	4]_____	_____
☐	☐	5] Diet (Do you eat health foods)?	5]_____	_____
☐	☐	6] Have you ever been in accidents?	6]_____	_____
☐	☐	7] Have you had surgery and organs removed/ replaced?	7]_____	_____
☐	☐	8] Drugs? (Prescriptive or non-prescriptive)	8]_____	_____
☐	☐	9] Teeth problems?	9]_____	_____
☐	☐	10] Eye problems?	10]_____	_____
☐	☐	11] Hearing problems?	11]_____	_____
☐	☐	12] Exercise regularly?	12]_____	_____
☐	☐	13] Sleeping habits? (nightmares, etc)	13]_____	_____
☐	☐	14] Did/do you have occupational stress?	14]_____	_____
☐	☐	15] Physical stress?	15]_____	_____
☐	☐	16] Mental stress?	16]_____	_____
☐	☐	17] Hobbies/Sports injuries?	17]_____	_____
☐	☐	18] Other traumas or problems	18]_____	_____

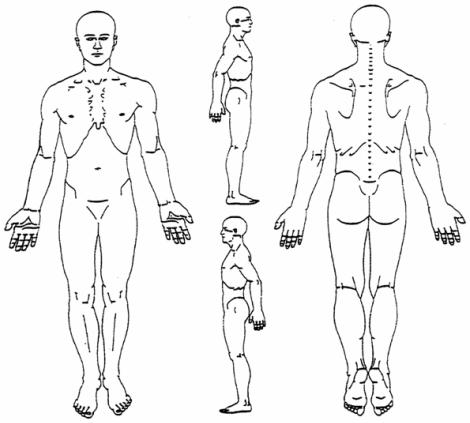
Symptoms and Ill Health (Present State of Ill Health)

Years of untreated damage showed up as acute or chronic symptoms.

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

Present Complaint

Major Complaint _____
When did the problem begin? (Date) _____
What happened? What is the mechanism of the injury?_____
_____
Onset (Circle one): Sudden, Gradual, Unknown
What positions, activities, or movements make each symptom **better or worse**? Is it constant?
_____
Does it have an **impact** on sleep, work, hobbies, home life, activities of daily living, domestic duties, enjoyment, etc?
_____
Describe the **quality** of the pain: (Ex: Sharp, dull, aches, burning, throbbing, etc)
_____
Does the pain **radiate**? Left or right? Indicate on the diagram.
What is the **intensity**? (Circle one): (Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
What is the **frequency**, in a percentage of awake time? _____%
For each symptom, are **certain times of the day worse**? (Circle): Morning Afternoon Evening Wakes me up Unaffected by time of day
Please note any **medications, treatments, or surgeries** related to present condition:_____
_____



Family History

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