

# Case History

Name \_\_\_\_\_ Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
H. Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ W. Phone (\_\_\_\_) \_\_\_\_\_ Sex:  M  F  
E-Mail Address \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Marital Status: S M W D  
Spouse's name \_\_\_\_\_ Number of Children and Ages \_\_\_\_\_  
Referred by \_\_\_\_\_ Previous Chiropractor \_\_\_\_\_ or None  
What do you know or what have you heard about chiropractic? \_\_\_\_\_

## About Your Care

Chiropractic provides three types of care. The first is **Acute** or **Initial Intensive Care** which addresses your primary complaint and treats the most recent spinal and neurological damage. This care usually reduces or eliminates your primary symptoms. We call this **Relief Care**.

If you choose to continue, the second phase of care is called **Reconstructive, Rehabilitative** or **Corrective Care**. This phase of care addresses and attempts to correct the underlying damage that has occurred as a result of this injury.

Finally, Chiropractic offers a genuine approach to **Wellness** or **Maintenance Care**. We hope that you choose Wellness Care. This is the care that leads to a long and healthy expression of life. These options will be explained during your report of findings. You'll then be able to begin a course of care that fits your health and wellness goals.

## Primary Complaints and Initial Consultation

What is your Primary or Major Complaint? \_\_\_\_\_  
Do you have a Secondary Complaint? \_\_\_\_\_ Third? \_\_\_\_\_  
Does anyone else in your family have a history of this complaint? \_\_\_\_\_  
How long have you been suffering with this? \_\_\_\_\_  
How often do you suffer? (Constant or comes/goes) \_\_\_\_\_  
Was there an earlier accident or injury that may have been directly related to this problem? (Example: fall, auto or work injury, sports trauma or repetitive motion?) \_\_\_\_\_  
What if anything, have you tried that didn't work? (Ice, Heat, PT, Meds, other): \_\_\_\_\_  
Have you become discouraged about this?  Yes  No In what way? \_\_\_\_\_  
When this problem is at its worse, does it make you feel older than you are?  Yes  No How old? \_\_\_\_\_  
Does this condition affect your family, work, recreation or free time? \_\_\_\_\_

(Continue on other side)

Has this problem interrupted your sleep? (Difficult falling to sleep, not sleeping restfully, frequently awakening or awakening earlier than usual? \_\_\_\_\_

Has this problem caused you to miss any activities? \_\_\_\_\_

What would happen if the problem doesn't get handled for several more months/years? \_\_\_\_\_

### Associated Symptoms

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Migraines                          | <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Loss of Balance          |
| <input type="checkbox"/> Ears Ringing       | <input type="checkbox"/> Ears Buzzing                       | <input type="checkbox"/> Light Sensitivity             | <input type="checkbox"/> Blurred Vision           |
| <input type="checkbox"/> Memory Loss        | <input type="checkbox"/> Face Flushed                       | <input type="checkbox"/> Loss of Smell                 | <input type="checkbox"/> Loss of Taste            |
| <input type="checkbox"/> Sinus              | <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Frequent Colds/Bronchitis     | <input type="checkbox"/> Fever/Chills             |
| <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> Shoulder Pain R/L                  | <input type="checkbox"/> Arm Pain R/L                  | <input type="checkbox"/> Elbow Pain R/L           |
| <input type="checkbox"/> Neck Stiffness     | <input type="checkbox"/> Wrist Pain R/L                     | <input type="checkbox"/> Hand Pain R/L                 | <input type="checkbox"/> Cold Hands R/L           |
| <input type="checkbox"/> TMJ/Jaw Pain R/L   | <input type="checkbox"/> Pins & Needles in Arms/Hands R/L   | <input type="checkbox"/> Numbness in Fingers R/L       | <input type="checkbox"/> Cold Sweats              |
| <input type="checkbox"/> Upper Back Pain    | <input type="checkbox"/> Chest Pain                         | <input type="checkbox"/> Shortness of Breath           | <input type="checkbox"/> Heartburn/Acid Reflux    |
| <input type="checkbox"/> Mid Back Pain      | <input type="checkbox"/> Asthma or Emphysema                | <input type="checkbox"/> Upset Stomach/Nausea          | <input type="checkbox"/> Vomiting                 |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Liver or Gall Bladder Complaints   | <input type="checkbox"/> Constipation or Diarrhea      | <input type="checkbox"/> Abdominal Pain           |
| <input type="checkbox"/> Irritable Bowel    | <input type="checkbox"/> Crohn's Disease/Ulcerative Colitis | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Celiac Disease           |
| <input type="checkbox"/> Lower Back Pain    | <input type="checkbox"/> Hip Pain R/L                       | <input type="checkbox"/> Leg Pain R/L                  | <input type="checkbox"/> Knee Pain R/L            |
| <input type="checkbox"/> Ankle Pain R/L     | <input type="checkbox"/> Pins & Needles in Legs/Feet R/L    | <input type="checkbox"/> Foot Pain R/L                 | <input type="checkbox"/> Numbness in Toes         |
| <input type="checkbox"/> Cold Feet R/L      | <input type="checkbox"/> Restless Leg Syndrome              | <input type="checkbox"/> Difficulty Sleeping           | <input type="checkbox"/> Fatigue                  |
| <input type="checkbox"/> Tension            | <input type="checkbox"/> Irritability                       | <input type="checkbox"/> Moodiness                     | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Loss of Energy     | <input type="checkbox"/> Thyroid Condition _____            | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> High Cholesterol or Triglycerides  | <input type="checkbox"/> Fibromyalgia                  | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> PMS                | <input type="checkbox"/> Painful Periods                    | <input type="checkbox"/> Menstrual Irregularity        | <input type="checkbox"/> Hot Flashes              |
| <input type="checkbox"/> Poor Libido or ED  | <input type="checkbox"/> Unusual Hair Loss or Dry Skin      | <input type="checkbox"/> Psoriasis or Eczema           | <input type="checkbox"/> ADD or ADHD              |
| <input type="checkbox"/> Osteoarthritis     | <input type="checkbox"/> Rheumatoid Arthritis               | <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Other: _____             |

### Current Health Habits

- |  | Yes                      | No                       |                                       | Yes                      | No                       |
|--|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| Do you smoke cigarettes?                 | <input type="checkbox"/> | <input type="checkbox"/> | Do you regularly drink alcohol?       | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you a coffee drinker?                | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink tea daily?               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink sodas daily?                | <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a lot of sweets?           | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink 8 or more glasses of water? | <input type="checkbox"/> | <input type="checkbox"/> | Do you take supplements?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you exercise regularly?               | <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a lot of fried foods?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you work more than 40 hrs/week?       | <input type="checkbox"/> | <input type="checkbox"/> | Are you under emotional stress?       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get 8 hours of sleep/night?       | <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty sleeping?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you frequently experience fatigue?    | <input type="checkbox"/> | <input type="checkbox"/> | Do you wish you had more energy?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you on anti-depressant medication?   | <input type="checkbox"/> | <input type="checkbox"/> | Ever taken medication for depression? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you in a difficult relationship?     | <input type="checkbox"/> | <input type="checkbox"/> | Are you often moody or irritable?     | <input type="checkbox"/> | <input type="checkbox"/> |

List any medications that you are currently taking and what they are for: \_\_\_\_\_

List any supplements that you are currently taking: \_\_\_\_\_

**How do you want us to handle your problem?** (check one)

\_\_\_\_\_ Relief Care (Help the symptom but not fix the cause of the problem)

\_\_\_\_\_ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

**Is your health a priority?** On a scale of 1-10 (10 being the most and 1 being the least)

\_\_\_\_\_ **How committed are you at being at your maximum health potential?**