

CASE HISTORY

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

H. PHONE: _____ CELL: _____ WK: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: S M D W REFERRED BY: _____

SPOUSES NAME: _____ NUMBER OF CHILDREN _____ PREGNANT: Y N

EMAIL: _____ PREVIOUS CHIROPRACTIC CARE? Y N

OCCUPATION / EMPLOYER: _____

ABOUT YOUR HEALTH

THE HUMAN BODY IS DESIGNED TO BE HEALTHY. THROUGHOUT LIFE, EVENTS OCCUR THAT CAN DAMAGE YOUR HEALTH EXPRESSION. THIS CASE HISTORY WILL UNCOVER THE LAYERS OF DAMAGE, ESPECIALLY TO YOUR NERVOUS SYSTEM THAT RESULTED IN POOR HEALTH. FOLLOWING YOUR EXAM YOUR DOCTOR WILL OUTLINE A COURSE OF CARE THAT WILL BEGIN TO CORRECT THE LAYERS OF DAMAGE AND RECOVER YOUR INNATE HEALTH POTENTIAL.

PRESENT STATE OF HEALTH

PRESENT COMPLAINT (BE BRIEF) _____

PAIN OF PROBLEMS STARTED ON (DATE) _____

PAINS ARE: SHARP DULL CONSTANT ACHY

WHAT ACTIVITIES MAKE YOUR PAIN / CONDITION WORSE? _____

IS THIS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH: WORK? _____ SLEEP? _____ NORMAL ROUTINE? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? Y N

OTHER DOCTORS SEEN FOR THIS CONDITION? _____

ANY HOME REMEDIES? _____

OTHER PROBLEMS: _____

HAVE YOU BEEN UNDER MEDICAL CARE? Y N REASON: _____

WHAT MEDICATIONS ARE YOU TAKING? _____ HOW LONG? _____

WHAT SIDE EFFECTS HAVE YOU EXPERIENCED FROM THE MEDICATIONS AND OR SURGERIES? _____

HEALTH HISTORY

YES NO CURRENT HEALTH

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU BEEN IN ANY ACCIDENTS? |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU HAD ANY SURGERIES? |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU HAD ANY TEETH PROBLEMS? |
| <input type="checkbox"/> | <input type="checkbox"/> | EYE PROBLEMS? |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING PROBLEMS? |
| <input type="checkbox"/> | <input type="checkbox"/> | EXERCISE REGULARLY? |
| <input type="checkbox"/> | <input type="checkbox"/> | DO / DID YOU HAVE ANY PHYSICAL STRESS? |
| <input type="checkbox"/> | <input type="checkbox"/> | DO / DID YOU HAVE ANY MENTAL STRESS? |
| <input type="checkbox"/> | <input type="checkbox"/> | DO / DID YOU SMOKE? |
| <input type="checkbox"/> | <input type="checkbox"/> | DO / DID YOU DRINK ALCOHOL? |

OTHER SYMPTOMS: (CHECK ALL THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> COLD SWEATS |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> NUMBNESS IN FINGERS | <input type="checkbox"/> FEVER |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> NUMBNESS IN TOES | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> COLD HANDS |
| <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> COLD FEET |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> UPSET STOMACH | <input type="checkbox"/> SENSITIVE TO LIGHT | <input type="checkbox"/> TENSION |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> LOSS OF MEMORY | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> LOSS OF TASTE | <input type="checkbox"/> LOSS OF SMELL |
| <input type="checkbox"/> SLEEPING PROBLEMS | | |

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____ EMPLOYER: _____

ARE YOU INSURED? YES NO

COMPANY: _____ PHONE: () _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CARE PROGRAM

THE PURPOSE OF STRAIGHT CHIROPRACTIC CARE AT THIS OFFICE CONSISTS OF THE DETECTION, LOCATION AND CORRECTION OF THE VERTEBRAL SUBLUXATION, WHICH PRODUCES INTERFERENCE ON THE BRAIN STEM AND OR SPINAL CORD AND NERVES. THERE ARE THREE PHASES OF CARE. THE FIRST IS THE *RELIEF PHASE*, WHICH CORRECTS THE MOST RECENT LAYER OF SPINAL AND NEUROLOGICAL DAMAGE. THIS PHASE USUALLY REDUCES OR ELIMINATES THE SYMPTOMS. THEN BEGINS THE *CORRECTION PHASE*, WHICH CORRECTS THE YEARS OF DAMAGE THAT OCCURRED WHEN THERE WERE FEW SYMPTOMS. FINALLY WE OFFER A GENUINE APPROACH TO *WELLNESS CARE* (ALSO KNOWN AS THE *STRENGTHENING PHASE*), WHICH IS LONG TERM AND MOST BENEFICIAL. 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. NO DIAGNOSIS, TREATMENT OR CURING OF DISEASE IS OFFERED AT THIS OFFICE. I ACCEPT CHIROPRACTICE CARE ON THIS BASIS ALONE.

PLEASE SIGN BELOW TO INDICATE THAT ALL INFORMATION PROVIDED IS ACCURATE AND THOROUGH.

SIGN: _____ DATE: _____