Confidential Patient Case History

#____________

Name:____________________________ Age: ___________ Today's Date: ________________

Address: ____

Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: (   ) _________________ Work Telephone Number: (   ) ______________________

Email: ______________________________ Birth date: ____________________ Male: __ Female: __

Occupation: _____________________ Employed by: ____

Do you have extended health care? ☐ YES ☐ NO

Partner/Spouse's Name:____

Number of children: ______ Names of children: ____

Have you had previous chiropractic care? (circle one) Yes No Chiropractor's name: ____________________

What type of care are you interested in? ☐ Temporary relief ☐ Maximum correction

Medical Doctor's name and phone number: ____

Who may we thank for referring you to our office?____

Your Health Profile

About Your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimum health potential. Please take a moment now to fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation of the layers of damage that may exist in your body which are helping to block your body's innate ability to be well and healthy.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐

	Yes	No	Unsure
Were you involved in any car accidents as a child?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

#____________

Symptoms and ill health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

If you have a specific chief complaint, please describe briefly. *If not, please go to next page.*

____

____

How and when did this problem start? ____________________________________

____

Does the pain radiate or travel anywhere else? ______________________________

Is the problem… ☐ constant ☐ intermittent ☐ worse with movement

Is condition worse… ☐ in the A.M. ☐ in the P.M. ☐ no change

Is the condition interfering with…
☐ sleep ☐ work ☐ routine ☐ other ___________

Is condition getting progressively worse? ☐ Yes ☐ No

Pain is… ☐ sharp ☐ dull ☐ throbbing
☐ aching ☐ shooting ☐ nagging ☐ other ___________

What aggravates your condition / pain?
____

What relieves your condition / pain?
____

If your condition was treated in the past, please describe treatment and results.

____

____

Have you had x-rays taken of this area? ☐ Yes ☐ No

Secondary complaints?
____

____

Have you ever or do you presently suffer from any of the following symptoms?
Please list present treatment and include any medications being taken.

☐ Headaches	☐ Ears ring	☐ Stiff/painful neck	☐ Nervousness
______________	______________	______________	______________
☐ Depression	☐ Tension	☐ Fatigue	☐ Sleep problems
______________	______________	______________	______________
☐ Chest Pains	☐ Heart/lung trouble	☐ Digestive disorders	☐ Menstrual problems
______________	______________	______________	______________
☐ Numbness or pins & needles in legs	☐ Arms, wrists & hands	☐ Cold feet/hands	☐ Arthritis - where?
______________	______________	______________	______________

Are there any other medication or treatment you are receiving? (include birth control pills)

____

____

List any surgeries and include when?

____

____

What if any side effects have you experienced from your medications or surgery?

____

____

Is there a family history of:

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

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. This care 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

#____________

Please check any of the following you have experienced and provide us with some details.

Spinal/nerve system Stress

	YES	NO
You feel that you have good posture?	☐	☐
If no, when did that begin?____		
Are you concerned that your posture is getting worse?	☐	☐
Have you had any :		
Major slips/falls____	☐	☐
Work related injuries____	☐	☐
Broken Bones____	☐	☐
Do you receive massage therapy?	☐	☐
Are you seeing any other natural health professionals?	☐	☐
If yes, please provide some details as to who you are seeing, why and the results you have experienced____		
Do you experience more tension in one side of your spine? ☐ right ☐ left	☐	☐
Have you had any sports injuries?________________________________	☐	☐
Do you feel that you have a strong immune system?	☐	☐
Have you ever been told that you have an autoimmune disease? ______________	☐	☐
Do you wear supportive footwear?	☐	☐
Do you have or have you ever had orthotics for your feet?	☐	☐
Do you sleep on your stomach?	☐	☐
Do you spend long hours in front of a computer?	☐	☐
Do you spend long hours driving?	☐	☐

On a scale of 1-10 please mark where you feel the health of your spine is currently

1_______2_______3________4__________5_______6_______7_______8______9_______10

Nutrition/Chemical:

Do you feel that you eat a healthy diet?	☐	☐
Have you been overweight in the past?	☐	☐
Do you struggle to maintain a healthy weight?	☐	☐
Do you take any medications?	☐	☐
If yes, how many and how often (please include over the counter medications as well)____		
Are you finding yourself taking more medications lately?	☐	☐
Do you take and vitamins or other supplements? ________________________	☐	☐
Are you exposed to harmful chemicals at work?	☐	☐
Do you smoke?	☐	☐
Do you eat an excessive amount of sugar?	☐	☐

On a scale of 1-10 please indicate where you feel your health falls in this category. (nutrition/lack of drugs and harmful chemicals).

1_______2_______3________4__________5_______6_______7_______8______9_______10

#_____________

	YES	NO

Exercise:

	YES	NO
Do you exercise regularly?	☐	☐

If yes, please provide some details as to the type of activity and frequency:
Cardio ____
____

Muscle strengthening____
____

Sports____
____

	YES	NO
Do you stretch on a regular basis?	☐	☐
If yes, how often and what areas? ___________________________________		
Where did you learn the stretches?___________________________________		
Are you involved in any extreme sports?	☐	☐
Do you wear proper footwear when you work out?	☐	☐

On a scale of 1-10 please indicate where you feel your health falls in this category (exercise/flexibility/motion)

1_______2_______3________4__________5_______6_______7_______8______9_______10

Thoughts/emotional stress

	YES	NO
Have you had a major life change recently?	☐	☐

(i.e marriage, divorce, career change, moving, breakdown in relationship, loss of a loved one)
If yes, please explain briefly:____
____

	YES	NO
Do you have relationships in your life that is causing you ongoing stress?	☐	☐
How many hours a night do you sleep? _______________________________		
Do you sleep soundly?	☐	☐
Do you find your work stressful? (stay at home Moms included)	☐	☐
Is your life very fast paced?	☐	☐
Do you worry about the future a great deal?	☐	☐
Do you feel you manage stress well?	☐	☐
Do you use proper breathing techniques to relax?	☐	☐
Do you have hobbies/activities that you use to relax/decompress?	☐	☐

If yes, please explain____

On a scale of 1-10 please indicate where you feel your health falls in this category (emotional stress)

1_______2_______3________4__________5_______6_______7_______8______9_______10