

CASE HISTORY

Name: _____ Sex: M F
 Address: _____
 City: _____ Postal Code: _____ Email Address: _____
 Home Telephone: _____ Age: _____ Birthdate: (D/M/Y) _____ Status: M S W D
 Employer: _____ Telephone: _____ Ext. _____
 Occupation: _____ Referred by: _____
 Spouse Name: _____ # of Children: _____ and their ages: _____

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 have 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.

LOSS OF WHOLE BODY HEALTH (BIRTH TO PRESENT)

From birth, certain stresses in your life start to produce layers of damage to your spine and nervous system. Eventually you may have begun to experience symptoms and random bouts of sickness.

Birth Process / Growth Development

Was your delivery difficult? YES NO Forceps Cesarean Breech

Were you breast fed? YES NO Childhood sickness? Please list _____

Ear infections? YES NO Were you given antibiotics? YES NO

Were you yanked by the arm? YES NO Have you fallen down the stairs? YES NO

Yes	No	(Age 5 to present)	Patient Comment (if Yes)	Chiropractor's Comment
<input type="radio"/>	<input type="radio"/>	Were you taught proper body movement and care?	_____	_____
<input type="radio"/>	<input type="radio"/>	Did/do you smoke?	_____	_____
<input type="radio"/>	<input type="radio"/>	Did/do you drink alcohol?	_____	_____
<input type="radio"/>	<input type="radio"/>	Diet (do you eat healthy foods?)	_____	_____
<input type="radio"/>	<input type="radio"/>	Have you been in accidents?	_____	_____
<input type="radio"/>	<input type="radio"/>	Have you had surgery; organs removed/replaced?	_____	_____
<input type="radio"/>	<input type="radio"/>	Drugs? (Prescriptive or non-prescriptive)	_____	_____
<input type="radio"/>	<input type="radio"/>	Teeth problems?	_____	_____
<input type="radio"/>	<input type="radio"/>	Eye problems?	_____	_____
<input type="radio"/>	<input type="radio"/>	Hearing problems?	_____	_____
<input type="radio"/>	<input type="radio"/>	Exercise regularly?	_____	_____
<input type="radio"/>	<input type="radio"/>	Sleeping habits? (Nightmares)	_____	_____
<input type="radio"/>	<input type="radio"/>	Did/do you have occupational stress?	_____	_____
<input type="radio"/>	<input type="radio"/>	Physical stress?	_____	_____
<input type="radio"/>	<input type="radio"/>	Mental stress?	_____	_____
<input type="radio"/>	<input type="radio"/>	Hobbies/Sports injuries?	_____	_____
<input type="radio"/>	<input type="radio"/>	Other traumas or problems	_____	_____
		Sleeping posture <input type="radio"/> Side <input type="radio"/> Stomach <input type="radio"/> Back		

What is your major complaint presently: _____

How long have you had this condition? _____ Have you had a similar condition in the past? _____

What activities aggravate your condition? _____

What relieves your condition? _____

Are you getting pain or numbness in your Arms Hands Head Buttock Legs Calf Foot

Is your condition getting progressively worse? Yes No It's constant It comes and goes

Pains are: Sharp Dull Burning Tightness Throbbing

Is this condition interfering with your: Work Daily Routine Other

Have you had previous chiropractic care? _____ Where? _____ When? _____

Why? _____ Dr: _____ Were X-rays taken? _____

Other doctor(s) who have treated this condition: _____

List all surgical operations and years: _____

Name of your family doctor: _____ Phone #: _____

Drugs you now take: Anti-inflammatory Pain killers Muscle relaxers Blood pressure

Tranquilizers Insulin Birth Control Pills Other:

Age of mattress: _____ Comfortable Uncomfortable

Are you wearing: Heel lifts Sole lifts Inner Soles Arch Supports

Have you been in an automobile accident? No Past year 2 to 5 years Over 5 years

Describe the accident: _____

Have you had any other personal injury or accident? None Past year 2 to 5 years Over 5 years

Describe the accident: _____

Date of last physical examination: _____

Is there a possibility that you may be pregnant? Yes No

Do you have a family history of any of the following: Cancer Yes No

Diabetes Yes No

Heart Disease Yes No

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that Barrow Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor.

I have read the above statements and consent to treatment.

Signature: _____ Date Signed: _____