

Case History

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 H. Phone (____) _____ W. Phone _____ Date of Birth _____ (Age _____)
 Referred by _____ Social Security # _____
 Occupation _____ Employer _____
 Marital Status S M D W Spouses Name _____
 Spouses Occupation _____ Number of Children and Ages _____
 Have you ever received Chiropractic Care? Yes No

Email: _____

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.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

			Patient Comment if answer is Yes	Chiropractor's Comments
Yes	No			
		1. Birth Process		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
		2. Growth and Development		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you a headbanger or rocker?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear/chin	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? What? When?	_____	_____