Elena Pekurovsky, D.C., L.Ac.
Amberlight Chiropractic & Wellness
8421 Wayzata Blvd # 230,Golden Valley, MN 55426

ph. (612) 242-1335

Case History

Today date_______________
Name____ Date of Birth_________ Age_______
Phone: Hm________________________ Cell _____________________ Wk ______________ -
Address____ City_____________________ State_________________ Zip___________
E-mail address______________________________________ Referred by____
Occupation________________________Employer_______________________ Marital Status S M D W
Spouse Name__________________ Spouses Occupation___________________ Number of Children/Ages______________________
Emergency contact name____________________________________ and ph. (not listed above) _____________________________
Have you ever received Chiropractic/Acupuncture Care? Yes No When was the last treatment?________________

<u>About Your Health</u>

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will help to uncover the possible reasons of improper functioning of the body. Following your exam, your doctor will outline a course care to begin to correct these layers of damage and to help you recover your inner health potential.

<u>Loss of Wellness</u>

Let's begin at your birth, when you may have first damaged your health, lost wellness, and began your journey to your present condition.

1. Regarding your Birth Process (*circle if answer is Yes*):
Was the delivery long/difficult Forceps or extraction used Cesarean/ C-Section
Breach Home birth Hospital birth Mother given drugs during delivery Induced labor
____
____

2. Regarding your Growth & Development/Childhood(*circle if answer is Yes*):
Breast fed? Childhood illnesses? Ear infections/ Colic/ Asthma? Attention Deficit? Accidents? Drugs, including prescription? Surgery? Did you fall down stairs? Chair pulled out when sat down? Were you yanked by your arm? Did you have other traumas? Did you ever break any bones?

---

3. Current Health Habits:
Did/do you smoke? Y N ____________________________ ____________________
Did/do you drink alcohol? Y N ____________________________ ____________________
Diet, do you eat healthy foods? Y N ____________________________ ____________________
Have you been in accidents/trauma? Y N ____________________________ ____________________
Surgeries and organs removed/replaced? Y N What kind? When?____
Any side effects from the drugs and surgery? Y N____
Implanted medical devices? Y N ____________________________ ____________________
Drugs, including Prescription? Y N List ____
Supplements/Herbs? Y N ____________________________ ____________________
Teeth problems? Eye problems? Y N ____________________________ ____________________
Hearing problems? Y N ____________________________ ____________________
Current exercises or sport activities Y N ____________________________ ____________________
What are your hobbies/pleasures? ____
Did/do you have occupational stress? Y N ____________________________ ____________________
Physical stress? Y N ____________________________ ____________________
Emotional/Mental stress? Y N ____________________________ ____________________
Hobbies/Sports injuries? Y N ____________________________ ____________________
Do you sleep well? Y N Do you dream? Y N ____________________________ ____________________
Sleeping posture? O side O stomach O back ____________________________ ____________________

Patient name ________________________________ Date _____________

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the body may show up as acute or chronic symptoms.

Briefly describe your symptoms/ health concerns/ primary reason for visit: ____________________________
When did it started ____
How did it started: ____
Please Circle where you're at:
1. Last 24 hours: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)
2. In the past 2 weeks: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)
Pains are: ***O Sharp O Heavy O Distending O Dull/ Ache O Colicky O Pulling***
O Burning O Hollow O Stabbing **O Throbbing** ***O Other*______________________**
How often do you experience your symptoms?
O Constantly (76-100 % of the time) O Frequently (51-75%) O Occasionally (26-50%) O Intermittently (0-25%)
How much have your symptoms interfered with your daily activities?
O Not at all O A little bit O Moderately O Quite a bit O Extremely
Does this pain shoot, radiate, or travel in your body? Where? ____________________________________
Are you experiencing numbness or tingling in any area of your body? Where? _________________________
What activities make your condition/pain worse? ____
What activities make your condition/pain better? ____
Best and worst time of the day/night____

Is this condition interfering with __ Work __Standing __Sexually __Other:
__Sleep __Emotional __Recreation ________________________
__Walking __Relationships __Bending ________________________
__Sitting __Social Life __Stretching ________________________

What have you done about this? Home remedies? ____
Is this condition progressively getting worse? ____
Other Doctors seen for this condition____

In general, would you say your overall health right now is: *O* Excellent *O* Very good *O* Good *O* Fair *O* Poor
What are your health goals?____

Please mark any of the following that you have now or have experienced:

O Headaches
O Neck Pain/stiffness
O Pain between Shoulders
O Shoulder Pain
O Low Back Pain
O Pain /Numbness in Hands or Arms
O Pain/ Numbness in Legs or Feet
O Joint Swelling
O Arthritis
O Dizziness
O Loss of Balance
O Sleeping Problems
O Nervousness
O Tension
O Irritability
O Loss of Memory
O Allergies/Sensitivities___________
O Loss of Smell or Taste
O Fatigue
O Depression O Epilepsy
O Seizures
O Multiple Sclerosis
O Mental breakdown
O Mental illness
O Hypo/hyper thyroid
O Diabetes
O Obesity
O Jaundice
O Hepatitis
O Diarrhea
O Constipation
O Stomach Upset
O Weight Loss
O Lights Bother Eyes
O Anemia
O Blood transfusion
O Chest Pains
O Heart disease
O Heart Attack
O High/Low Blood Pressure
O Stroke
O Fever
O Sinus problems
O Shortness of Breath
O Pneumonia
O Tuberculosis
O Asthma
O Cancer
O Painful Urination
O Kidney stones
O HIV/AIDS
O STD
O Parasites
O Skin/hair problems

Females Only – Date last Menstrual Period began on___________ Is your cycle regular? Yes No Menstrual cramps? Yes No
Have you ever been pregnant? Yes No Number of live births______ Birth Control? Yes No How long? _____________
Are you possibly pregnant now? Yes No O PMS O Clotting O Vaginal sores O Vaginal pain O Discharge

Are you currently under medical care? ____

Is there a Family History of:	Heart Disease	Arthritis	Cancer	Diabetes	Other ________________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Patient name ________________________________

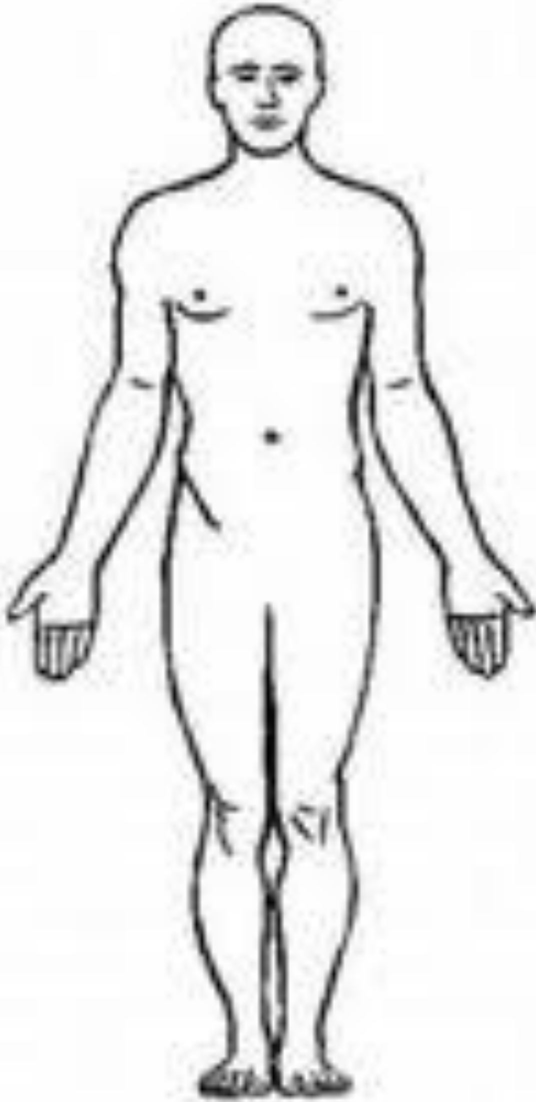
Mark the areas where you feel these sensations by using following symbols:

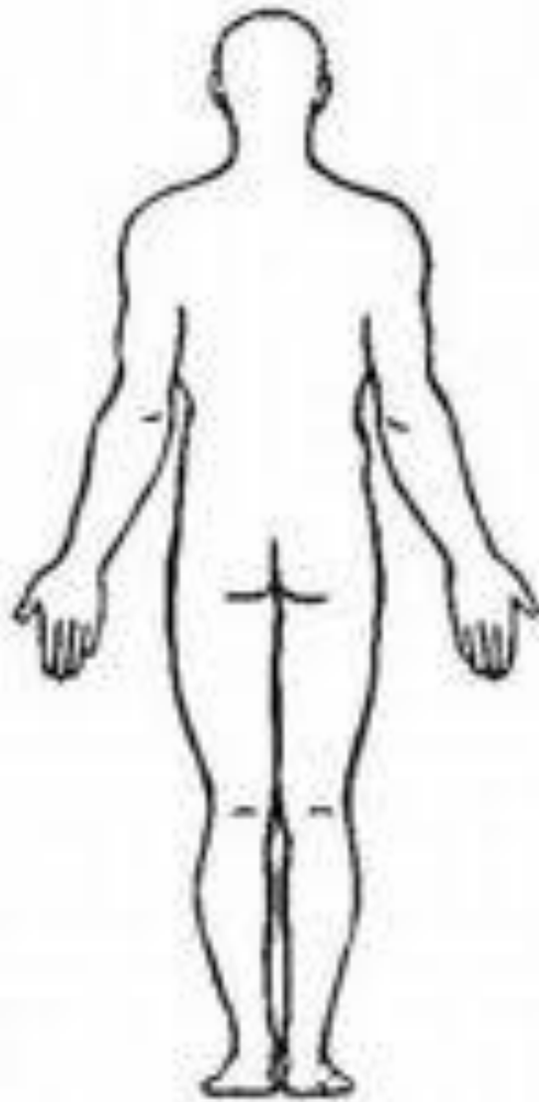
// // // numbness v v v pins & needles/tingling

x x x ache/dull ///// sharp

Grade your sensation level on the scale from 0 to 10, where 10 is the worst/most intense.

Right Left Left Right





About Your Care

There are three phases of care that our patients often go through. The first is Initial Intensive Care which corrects the most recent layer of damage. This care often reduces or eliminates the symptoms. Then Reconstructive Care begins which corrects the years of damage that occurred when there were few symptoms. And finally, 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 goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic/Chinese medicine care.

Patient or Guardian Signature____Date__________________