# Case History

Prepared for:

HOMEtown®
CHIROPRACTIC

## About Your Health

The human body is designed to be healthy. Throughout life, events occur that damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, which 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.

## About Your Care

Chiropractic provides three types of care. The first is conditioned-based care, which corrects the most recent layer of spinal and neurological damage. This care usually reduces or eliminates the symptoms. Then begins corrective 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 appointment, and then you can begin a course of care that fits your health goals and needs.

## Loss of Wellness | Birth to Age Five

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health commences.

| YES | NO | | PATIENT'S COMMENTS |
|---|---|---|---|
| | | **Pregnancy:** *Did your mother...* | |
| ☐ | ☐ | Smoke or drink alcohol | |
| ☐ | ☐ | Have a proper diet | |
| ☐ | ☐ | Exercise through her pregnancy | |
| ☐ | ☐ | Experience any falls and/or injuries during pregnancy | |
| ☐ | ☐ | Experience any physical and/or mental abuse | |
| | | **Birth Process** | |
| ☐ | ☐ | Was the delivery long | |
| ☐ | ☐ | Was the delivery difficult | |
| ☐ | ☐ | Forceps | |
| ☐ | ☐ | Cesarean | |
| ☐ | ☐ | Breach/cephalic | |
| ☐ | ☐ | Home birth | |
| ☐ | ☐ | Hospital birth | |
| ☐ | ☐ | Mother given drugs during delivery | |
| ☐ | ☐ | Labor was induced | |
| | | **Growth and Development** | |
| ☐ | ☐ | Were you taught how to care for your spine | |
| ☐ | ☐ | Did you roll out of bed | |
| ☐ | ☐ | Were you a head banger or rocker | |
| ☐ | ☐ | Were you breastfed | |
| ☐ | ☐ | Childhood sicknesses | |
| ☐ | ☐ | Accidents | |
| ☐ | ☐ | Surgery | |
| ☐ | ☐ | Drugs | |
| ☐ | ☐ | Did you fall while learning to walk | |
| ☐ | ☐ | Were you picked on by siblings | |
| ☐ | ☐ | Child abuse | |
| ☐ | ☐ | Spanking (how) | |
| ☐ | ☐ | Pulled ear/chin | |
| ☐ | ☐ | Chair pulled out when sat down | |
| ☐ | ☐ | Did you fall down the stairs | |
| ☐ | ☐ | Were you yanked by your arm | |
| ☐ | ☐ | Did you have other traumas: what, when | |
| ☐ | ☐ | Other: | |

## Loss of Whole-body Health | Age Five to Present

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

| YES | NO | | PATIENT'S COMMENTS |
|---|---|---|---|
| ☐ | ☐ | Were you taught proper body movement and care | |
| ☐ | ☐ | Did/do you smoke | |
| ☐ | ☐ | Did/do you drink alcohol | |
| ☐ | ☐ | Diet (do you eat healthy foods) | |
| ☐ | ☐ | Have you ever been in accidents | |
| ☐ | ☐ | Have you had surgery and organs removed/replaced | |
| ☐ | ☐ | Drugs (prescriptive or non-prescriptive) | |
| ☐ | ☐ | Teeth problems | |
| ☐ | ☐ | Eye problems | |
| ☐ | ☐ | Hearing problems | |
| ☐ | ☐ | Exercise regularly | |
| ☐ | ☐ | Sleeping habits (nightmares) | |
| ☐ | ☐ | Did/do you have occupational stress | |
| ☐ | ☐ | Physical stress | |
| ☐ | ☐ | Mental stress | |
| ☐ | ☐ | Hobbies/sports injuries | |
| ☐ | ☐ | Other traumas or problems | |

## Symptoms and Ill Health | Present State of Ill Health

Years of untreated damage show up as acute or chronic symptoms.
Please check all that apply.

- ☐ Headaches
- ☐ Neck pain
- ☐ Sleeping problems
- ☐ Back pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest pain
- ☐ Dizziness
- ☐ Face flushed
- ☐ Stiff neck
- ☐ Pins and needles in legs
- ☐ Pins and needles in arms
- ☐ Numbness in fingers
- ☐ Numbness in toes
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Depression
- ☐ Lights bother eyes
- ☐ Loss of memory
- ☐ Fever
- ☐ Fainting
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Diarrhea
- ☐ Feet cold
- ☐ Hands cold
- ☐ Stomach upset
- ☐ Constipation
- ☐ Cold sweats
- ☐ Loss of balance
- ☐ Buzzing in ears / ringing

### Present Complaint

Major complaint:______________________________

Pain or problem started when:______________________________

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent    Is condition getting progressively worse: ☐ Yes ☐ No

What activities aggravate your condition/pain:______________________________

Is condition worse during certain times of the day: ☐ Yes ☐ No If yes, when: ______________________________

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other:______________________________

Other doctors seen for this condition:______________________________

Any home remedies:______________________________

## Symptoms and Ill Health | Present State of Ill Health, *continued*

Have you been or are you taking medication and/or under medical care: ☐ Yes ☐ No

If yes, please explain: ______________________________

What medications are you taking: ______________________________

Have you had surgery: ☐ Yes ☐ No

For what: ______________________ When: ______________________

What side effects (if any) did you experience from drugs and/or surgery: ______________________

### Family History

| MOTHER | FATHER | | PATIENT'S COMMENTS |
|---|---|---|---|
| ☐ | ☐ | Heart disease | ______________________ |
| ☐ | ☐ | Arthritis | ______________________ |
| ☐ | ☐ | Cancer | ______________________ |
| ☐ | ☐ | Diabetes | ______________________ |
| ☐ | ☐ | Other: | ______________________ |

## Patient Information

Date: ______________

Name: ______________________________ Social Security#: ______________

☐ Male ☐ Female Date of birth: ______________________ Age: ______________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address: ______________________ City: ______________ State: ________ Zip: ________

Cell #: ______________ Home #: ______________ Work #: ______________

Occupation: ______________________ Employer: ______________________

Spouse's name and occupation: ______________________________

Number of children and ages: ______________________________

Have you received chiropractic care before: ☐ Yes ☐ No If you were referred, by whom: ______________

Have you ever been in an accident: ☐ Yes ☐ No ☐ Work ☐ Auto ☐ Other: ______________

When: ______________________ Nature of accident: ______________________

Did you require post-accident hospitalization: ☐ Yes ☐ No Did you lose workdays as a result: ☐ Yes ☐ No

How many: ________ Is/was insurance involved: ☐ Yes ☐ No Which company: ______________

Attorney's name: ______________________ Claim number: ______________________

**Comments:** (*office use only*) ______________________________

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