BUCKLE
FAMILY CHIROPRACTIC, PLLC
38807 Ann Arbor Rd., Ste. 5 · Livonia MI 48150 · 734.953.9933 · Fax 734.953.9966

CASE HISTORY

Please allow our staff to photocopy your driver's license & insurance information. All information will be confidential.

NAME_____DATE_____
ADDRESS_____CITY_____STATE____ZIP_____
HOME PHONE(____)_____ CELL PHONE(____)_____
EMAIL_____
BIRTH DATE_____ (AGE_____) MARITAL STATUS: S M D W
REFERRED BY_____
OCCUPATION_____EMPLOYER_____
EMERGENCY CONTACT_____PHONE#_____
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____YES ____NO

ABOUT YOUR HEALTH

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

1. BIRTH PROCESS

	Patient Comments	Dr's Comments
__Mother had an injury/fall when pregnant	_____	_____
__Mother given drugs during delivery	_____	_____
__Delivery was long or difficult	_____	_____
__Forceps/Vacuum used in delivery	_____	_____
__Labor was induced	_____	_____
__Cesarean Birth	_____	_____
__Breach Birth	_____	_____
__Home birth	_____	_____
__Hospital birth	_____	_____

2. GROWTH AND DEVELOPMENT (Birth – Teenager)

__Taught how to care for your spine	_____	_____
__Fell out of bed	_____	_____
__Had growing pains	_____	_____
__Had surgery	_____	_____
__Did you take drugs	_____	_____
__Experienced child abuse	_____	_____
__Experienced severe spanking	_____	_____
__Ear/chin pulled	_____	_____
__Fell down stairs	_____	_____
__Chair pulled out when sat down	_____	_____
__Yanked by your arm	_____	_____
__Bicycle/car/ATV accidents	_____	_____
__Did you have childhood sickness	_____	_____

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3. CURRENT HEALTH	Patient Comments	Dr's Comments
__Did/do you smoke	_____	_____
__Did/do you drink any alcohol	_____	_____
__Do you eat healthy foods	_____	_____
__Do you exercise regularly	_____	_____
__Have you had surgery	_____	_____
__Broken bones or dislocations	_____	_____
__Organs removed/ operated on	_____	_____
__Did/do you take prescriptive or Non-prescriptive drugs	_____	_____
__Did/do you have occupational stress	_____	_____
__Did/do you have physical stress	_____	_____
__Did/do you have mental stress	_____	_____
__Did/do you have sports injuries?	_____	_____

PRIMARY REASON FOR CONSULTING OFFICE

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint_____
Pain or problem started on_____
Pains are: _____SHARP _____DULL _____CONSTANT _____INTERMITTENT
Intensity: _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10
Frequency: _____Daily _____2-3 times weekly _____Sporatic
Is this condition worse at certain times of the day? ___Morning ___Afternoon ___Evening ___During sleep
Is this condition getting progressively worse?_____ Other doctors seen for this_____
Are you using any home remedies?_____
Have you been taking prescriptive or non-prescriptive drugs?_____
Any side effects from the drugs?_____

On the next page, please check the boxes on the right hand side under "EFFECT" of any health condition you may be experiencing now or in the past.

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Family Health Questionnaire

This is an additional questionnaire for those willing to radically improve their life. As your family chiropractor, I want to help you reach greater health and well-being according to your specific needs.

"True health is a state of optimal physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity."- Dorland's Medical Dictionary

Please rate your current Physical Health

1	2	3	4	5	6	7	8	9	10
Miserable				Symptomatic					Optimal

Please rate your current Mental Health

1	2	3	4	5	6	7	8	9	10
Suicidal				Fatigued/Stressed					Peaceful

Please rate your current Social/Relationship Health

1	2	3	4	5	6	7	8	9	10
Secluded				Irritable towards others					Loving

Please rate your current Spiritual Health

1	2	3	4	5	6	7	8	9	10
No Spirituality				On Purpose					Intimately Connected

Does your current health status prevent you from doing any of the following?

☐Recreation/sports	☐Performing at my best	☐Socializing
☐Family fun	☐Hobbies	☐Rest
☐Traveling	☐School work/Job	☐Other_____

Please check all that apply to you…

☐ I am interested in relieving my symptoms only (short-term relief care)

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☐ I am interested in short-term relief care and long-term reconstructive care

☐ I feel great now, but I want to include Chiropractic in my Wellness regimen to be and perform at my best.

☐ I am interested in having my entire family (significant other and/or children) scheduled for a Chiropractic health screening and examination.