Get Well Be Well

Striving to help you be happy, healthy and pain-free.

Chiropractic Case History

Name _____ Date_____
Address _____City_____ State____Zip_____
H. Phone _____C. Phone_____ DOB _____Age_____ Sex M F
How did you hear about us? _____
Marital Status S M D W
Number of Children/Ages_____
Occupation_____Employer_____
Have you ever received Chiropractic Care? Yes__ No__ If yes, when? _____

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 and spine that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

1. Primary reasons for seeking chiropractic care:

Primary reason: _____
Secondary reason: _____
Other reasons: _____

2. Past Health History:

Previous illnesses you've had in your life**:** _____
Previous injury or trauma**:**_____
Have you ever broken any bones? Which? _____
Allergies: _____
Medications: _____
Condition/s you are taking medications for: _____
Surgeries and dates: _____
Pregnancies, Date of Delivery & Outcomes _____
_____
Date of the beginning of your last menstrual period? _____ Any menstrual problems? _____
Are you currently pregnant? _____

3. Family Health History:

Associated health problems of relatives: _____
Deaths in immediate family: _____
Cause of parents or siblings death & age at death _____

4. Social and Occupational History:

Level of Education: _____
Job description: _____
Recreational activities: _____
Do you take vitamins or supplements? Type and how often? _____
Smoking and alcohol use. How often? _____

Please circle for each of the following:			Patient Comment If answer is Yes	Chiropractor's Comments
5. 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	_____	_____
Have you had surgery and organs removed/replaced?	Y	N	_____	_____
Drugs, including Prescription?	Y	N	_____	_____
Teeth problems?	Y	N	_____	_____
Eye problems?	Y	N	_____	_____
Hearing problems?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/Mental stress?	Y	N	_____	_____
Hobbies/Sports injuries?	Y	N	_____	_____
Sleeping posture? O side O stomach O back			_____	_____

6. Symptoms and Present State of Health

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

Present Complaint/Reason for Seeking Care in this Office:

Major_____

Pain or Problem started on _____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other _____

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 aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____Other? _____

Is this condition progressively getting worse? _____

Please Circle where you are:

(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other Doctors seen for this condition_____

Any home remedies? _____

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

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer

O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

Have you been under drug and medical care? _____
What Medications are you taking? _____
How long? _____ Have you had surgery? _____What? _____When? _____
What side effects have you experienced from the drugs and surgery? _____
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

On a scale of 1 – 10. How committed are you to resolving this complaint? _____
Are there any other health concerns you would like to address? _____

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often 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. Then you'll be able to begin a course of care that fits your goals.

I also understand that no cures are promised and any risks regarding care will be explained to me. I now authorize Maegan Istok, DC to proceed with necessary care and treatment.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____