



Date ____/____/____ Chart# _____

Last Name _____ First Name _____ Preferred Name _____
(if different from First Name)

Date of Birth ____/____/____ Age _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____

Email Address _____

How would you like to receive appointment reminders? (Choose all you would like.)

Cell Phone Text Email Reminder Phone Call (day before or morning of)

Occupation _____ Employer _____

Marital Status: S W D M Spouses Name _____ Children Y/ N Ages? _____

Have you ever received chiropractic care before? Yes No

If yes, please specify care plan: _____

Referred By _____

ABOUT YOUR HEALTH

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

Your Health History

Yes No

Y N Major illnesses or sickness? If yes, what?

Y N Any accidents/falls/traumas/automobile injuries? If yes, please list below.

Y N Drugs/medications? Please list what medications and for what conditions.
Ask the front desk staff to copy your medication list if you have one.

Y N Surgery? Please list below.

Y N Do you get common colds/illnesses often?

Y N Do you feel you have good immunity overall?

Y N Do you have a family history of any chronic illnesses or diseases? If yes, please list.

Your Current Health

Yes No

- Y N Did/Do you smoke?
Y N Did/Do you drink alcohol?
Y N Do you exercise regularly?
Y N Do you eat healthy?
Y N Do you get quality sleep?
How do you sleep? Stomach / Side / Back
Y N Do you play sports? Hobbies?
Y N Teeth/ Vision/ Hearing troubles?
Y N Have you been under drug or medical care for any conditions? If yes, please list. _____
-

Other Symptoms:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension/Irritability |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Not feeling like yourself |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Pains | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Ringing Ears | <input type="checkbox"/> Ear Ache/Infections | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tingling Feet | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Cold Hands/ Feet | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Colic | <input type="checkbox"/> _____ Other | |

Acute or chronic symptoms can often be traced back to damage from previous spinal macro and micro traumas. Tell us more about what you are experiencing:

Chief complaint _____

When did it start? _____ Complaint is: Sharp/ Dull/ Constant/ Intermittent

Which activity aggravates your condition? _____

Which activity lessens your condition? _____ Better or Worse / AM or PM

What is this condition interfering with? Activities/ Work/ Sleep/ Family/ Children/ Other: _____

Is the condition getting worse? _____

What have you done prior to your care here? _____ Any home remedies? _____

Notes:

Chiropractic Care at this office provides three types of care:

- **THE FIRST PHASE OF CARE IS THE INITIAL INTENSIVE CARE PHASE**
- **THE SECOND PHASE OF CARE IS THE CORRECTIVE OR SPINAL HEALING PHASE**
- **THE THIRD AND MOST IMPORTANT PHASE OF CARE IS HEALTH OPTIMIZATION/WELLNESS**

All of these options will be explained at your Report of Findings appointment. You will then be able to begin a course of care that best fits your health goals.