Name: Nickname: Age Date of Birth:

Address City State Zip

Phone (h) Phone (w) Cell

Occupation Employer

Marital Status(circle one) Single Married Divorced Widow Domestic Partner Email:

Partner's Name & Occupation

Number of Children: Children's Names & Ages:

Have you ever received Chiropractic Care? Yes No If yes, doctor's name/location

Referred by Hobbies:

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, that 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.

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	**No**		If Yes, Please Comment	Dr. Pat's Comment
		1. Birth Process		
O	O	Do you know any history of your birth?		
O	O	Was it difficult? Breech?		
O	O	Caesarean?		
		Home birth? Hospital birth? (Circle one)		
		2. Growth and Development		
O	O	Were you breast fed?		
O	O	Childhood sicknesses or accidents?		
O	O	Drugs?(Prescriptive and non-prescriptive)		
O	O	Childhood vaccinations?		
O	O	Exposure to toxins?		
O	O	Did you have any other traumas? What? When?		
		(examples: divorce, death, loss of job in household)		
Yes	**No**	**3. Current Health Habits**		
O	O	Did/do you smoke?		
O	O	Did/do you drink alcohol?		
O	O	Diet (Do you eat healthy foods)?		
O	O	Have you been in accidents?		
O	O	Have you had surgery?		
O	O	organs removed/replaced?		
O	O	Use recreational drugs?		
O	O	Exercise Regularly?		
O	O	Have you ever had a concussion?		
O	O	Are you a caregiver for someone?		

Circle to rate your STRESS level based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Work: 1 2 3 4 5 Financial: 1 2 3 4 5 Family: 1 2 3 4 5 Mental & Emotional Stress: 1 2 3 4 5

Chemical: 1 2 3 4 5 Physical Stress: 1 2 3 4 5 Other: 1 2 3 4 5

(Comment)

Sleeping Posture: O Side O Stomach O Back (Comment)

Circle to rate each: **1= Very Poor 2= Poor 3= Fair 4= Good 5= Excellent**

Sleep Quality	1	2	3	4	5	Energy Level	1	2	3	4	5
Life Enjoyment	1	2	3	4	5	Motivation	1	2	3	4	5

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage show up as acute or chronic symptoms. What brought you here?

Present Complaint_____

This started on _____

It feels like: (circle) Sharp Dull Aching Burning Radiating Itching Stabbing Other: _____

Is condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse or better? _____

Other Doctors seen for this condition? _____Any home remedies? _____

⇨ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

<Under-Aroused>	*<Un-Stable>*	*<Over –Aroused>*
O Poor Attention	O Migraines	O Cold hands
O Impulsive	O Headaches	O Cold feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth grinding
O Depressed	O Hot flashes	O Anxiety
O Lacking motivation	O PMS	O Heart Palpitations
O Poor Concentration	O Food sensitivities	O Restless Sleep
O Spaciness	O Bed wetting	O Poor expression of emotions
O Constipation	O Eating Disorder	O poor immune system
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty waking up	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>

O Cancer	O Rheumatoid Arthritis	O Diabetes
O Multiple Sclerosis	O Depression	O Chronic Fatigue Syndrome
O Fibromyalgia	O ALS (Lou Gehrig Disease)	O Epstein-Barr Syndrome

O Eczema or Skin problems	O Pins & Needles in Legs or Arms	O Buzzing in Ears	O Vision Problems
O Low Blood Pressure	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers & Toes	O Diarrhea	O Dizziness or Fainting	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Speech Difficulty	O ADHD or ADD

Have you been under drug and medical care?_____

What medications are you taking?(use back of page if needed)_____

How long have you been taking them? What side effects have you experienced ?_____

Is there a family history of : Heart Disease O Arthritis O Cancer O Diabetes O Other _____

On a Scale of 1 – 10, Rate the importance for you to achieve the following:	**1 = Not Important**									**10= Necessary**
Eat Better	1	2	3	4	5	6	7	8	9	10
Reduce Stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness and natural health care	1	2	3	4	5	6	7	8	9	10
Improve immune function	1	2	3	4	5	6	7	8	9	10
Improve mental function	1	2	3	4	5	6	7	8	9	10

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

(Signature) (Date)