43059 Seven Mile Road· Northville, MI 48167 · 248.449.1630 · Fax 248.449.1558

CASE HISTORY

NAME____DATE_______________________
ADDRESS____________________________CITY______________________STATE______________ZIP_____________
H. PHONE(_____)__________W. PHONE(_____)_______________DATE OF BIRTH_____________(AGE______)
REFERRED BY___________________________________SOCIAL SECURITY #___________________________
OCCUPATION____EMPLOYER______________________________
MARITAL STATUS: S M D W SPOUSES NAME__________________________________
SPOUSES OCCUPATION________________________________NUMBER OF CHILDREN & AGES____________
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.

YES	NO		PATIENT COMMENT If YES, please explain	CHIROPRACTOR'S Comments
		1.YOUR BIRTH PROCESS		
_____	_____	Did your mother experience any falls & injuries during pregnancy?	_______________	_______________
_____	_____	Was the delivery long?	_______________	_______________
_____	_____	Was the delivery difficult?	_______________	_______________
_____	_____	Forceps/vacuum?	_______________	_______________
_____	_____	Cesarean?	_______________	_______________
_____	_____	Breach?	_______________	_______________
_____	_____	Home birth?	_______________	_______________
_____	_____	Hospital birth?	_______________	_______________
_____	_____	Mother given drugs during delivery?	_______________	_______________
_____	_____	Was labor induced?	_______________	_______________
		2. GROWTH AND DEVELOPMENT (BIRTH THROUGH TEENAGE YEARS)		
_____	_____	Were you taught how to care for your spine?	_______________	_______________
_____	_____	Did you fall out of bed?	_______________	_______________
_____	_____	Did you have childhood sickness?	_______________	_______________
_____	_____	Did you have growing pains?	_______________	_______________
_____	_____	Did you have surgery?	_______________	_______________
_____	_____	Did you take drugs?	_______________	_______________
_____	_____	Did you experience child abuse?	_______________	_______________
_____	_____	Did you experience severe spanking?	_______________	_______________
_____	_____	Did you have your ear/chin pulled?	_______________	_______________
_____	_____	Chair pulled out when sat down?	_______________	_______________
_____	_____	Did you fall down stairs?	_______________	_______________
_____	_____	Were you yanked by your arm?	_______________	_______________
_____	_____	Bicycle/car/ATV accidents?	_______________	_______________

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YES	NO	3. CURRENT HEALTH		
_____	_____	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?____

OTHER SYMPTOMS THAT WE MAY HELP WITH:

_____HEADACHES/MIGRAINES	_____PINS & NEEDLES IN LEGS	_____LOSS OF SMELL
_____NECK PAIN	_____NUMBNESS IN FINGERS	_____LOSS OF TASTE
_____SLEEPING PROBLEMS	_____NUMBNESS IN TOES	_____DIARRHEA
_____BACK PAIN	_____SHORTNESS OF BREATH	_____FEET COLD
_____NERVOUSNESS	_____FATIGUE	_____HANDS COLD
_____TENSION	_____DEPRESSION	_____STOMACH UPSET/ACID REFLUX
_____IRRITABILITY	_____LIGHTS BOTHER EYES	_____CONSTIPATION
_____CHEST PAINS	_____SINUS PROBLEMS	_____MENSTRAL PROBLEMS
_____DIZZINESS	_____EARS RING	_____LOSS OF BALANCE
_____FACE FLUSHED	_____HOT FLASHES	_____BUZZING IN EARS
_____NECK STIFF	_____HIGH BLOOD PRESSURE	_____OTHER SYMPTOMS
_____DIFFICULTY CONCENTRATING		

Have you been under medical care recently or for this problem?_______________________________
Have you been taking prescriptive or non-prescriptive drugs?__________________________________
Any side effects from the drugs?____

Health for Life CHIROPRACTIC

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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
- ☐ Family fun
- ☐ Traveling
- ☐ Performing at my best
- ☐ Hobbies
- ☐ School work/Job
- ☐ Socializing
- ☐ Rest
- ☐ Other____________________

Please check all that apply to you…

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