# Case History

Prepared for:

JOURNEY
CHIROPRACTIC

## Loss of Wellness | Birth to Age Five

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health commences.

| YES | NO | | PATIENT'S COMMENTS |
|---|---|---|---|
| | | **Pregnancy:** *Did your mother...* | |
| ☐ | ☐ | Smoke or drink alcohol | |
| ☐ | ☐ | Have a proper diet | |
| ☐ | ☐ | Experience any falls and/or injuries during pregnancy | |
| ☐ | ☐ | Experience any physical and/or mental abuse | |
| | | **Your Mother's Birth Process:** *During your birth...* | |
| ☐ | ☐ | Was the delivery long | |
| ☐ | ☐ | Were forceps used | |
| ☐ | ☐ | Did she have a cesarean | |
| ☐ | ☐ | Were you breach/cephalic | |
| ☐ | ☐ | Home birth | |
| ☐ | ☐ | Was your mother given drugs during delivery | |
| | | **Growth and Development:** | |
| ☐ | ☐ | Were you taught how to care for your spine | |
| ☐ | ☐ | Were you breastfed | |
| ☐ | ☐ | Childhood sicknesses | |
| ☐ | ☐ | Accidents | |
| ☐ | ☐ | Surgery | |
| ☐ | ☐ | Drugs/medications | |
| ☐ | ☐ | Did you fall while learning to walk | |
| ☐ | ☐ | Spanking (how) | |
| ☐ | ☐ | Did you have a chair pulled out from under you | |
| ☐ | ☐ | Did you fall down the stairs | |
| ☐ | ☐ | Were you yanked by your arm | |
| ☐ | ☐ | Did you have other traumas: what, when | |
| ☐ | ☐ | Other: | |

## Loss of Whole-body Health | Age Five to Present

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

| YES | NO | | PATIENT'S COMMENTS |
|---|---|---|---|
| ☐ | ☐ | Did/do you smoke | |
| ☐ | ☐ | Did/do you drink alcohol | |
| ☐ | ☐ | Diet (do you eat healthy foods) | |
| ☐ | ☐ | Have you ever been in accidents | |
| ☐ | ☐ | Have you had surgery and organs removed/replaced | |
| ☐ | ☐ | Drugs (prescriptive or non-prescriptive) | |
| ☐ | ☐ | Teeth problems | |
| ☐ | ☐ | Eye problems | |
| ☐ | ☐ | Hearing problems | |
| ☐ | ☐ | Exercise regularly | |
| ☐ | ☐ | Do you sleep more than eight hours | |
| ☐ | ☐ | Did/do you have occupational stress | |
| ☐ | ☐ | Physical stress | |
| ☐ | ☐ | Mental stress | |
| ☐ | ☐ | Hobbies/sports injuries | |
| ☐ | ☐ | Other traumas or problems | |

## Present Complaint

Major complaint:_____

Pain or problem started when:_____

Pains are: ☐ Sharp ☐ Dull | ☐ Constant ☐ Periodic / Occasional Is condition getting progressively worse: ☐ Yes ☐ No

What activities aggravate your condition/pain:_____

Is condition worse during certain times of the day: ☐ Yes ☐ No If yes, when: _____

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other:_____

Other doctors seen for this condition:_____

Any home remedies:_____

## Symptoms and Ill Health | Present State of Ill Health

Years of untreated damage show up as acute or chronic symptoms.
Please check all that apply.

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Dizziness | ☐ Fatigue | ☐ Diarrhea |
| ☐ Neck pain | ☐ Face flushed | ☐ Depression | ☐ Feet cold |
| ☐ Sleeping problems | ☐ Stiff neck | ☐ Lights bother eyes | ☐ Hands cold |
| ☐ Back pain | ☐ Pins and needles in legs | ☐ Loss of memory | ☐ Stomach upset |
| ☐ Nervousness | ☐ Pins and needles in arms | ☐ Fever | ☐ Constipation |
| ☐ Tension | ☐ Numbness in fingers | ☐ Fainting | ☐ Cold sweats |
| ☐ Irritability | ☐ Numbness in toes | ☐ Loss of smell | ☐ Loss of balance |
| ☐ Chest pain | ☐ Shortness of breath | ☐ Loss of taste | ☐ Buzzing in ears / ringing |

Please explain: _____

_____

_____

Have you been or are you taking medication and/or under medical care: ☐ Yes ☐ No

If yes, please explain: _____

What medications are you taking:_____

Have you had surgery: ☐ Yes ☐ No

For what:_____ When: _____

What side effects (if any) did you experience from drugs and/or surgery: _____

## Family History

| MOTHER | FATHER | | PATIENT'S COMMENTS |
|---|---|---|---|
| ☐ | ☐ | Heart disease | _____ |
| ☐ | ☐ | Arthritis | _____ |
| ☐ | ☐ | Cancer | _____ |
| ☐ | ☐ | Diabetes | _____ |
| ☐ | ☐ | Other: | _____ |

## Patient Information

Date: _____

Name: _____

☐ Male ☐ Female Date of birth: _____ Age: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Occupation: _____ Employer: _____

Spouse's name and occupation: _____

Number of children and ages: _____

How did you hear about us: _____

Have you received chiropractic care before: ☐ Yes ☐ No If you were referred, by whom: _____

Have you ever been in an accident: ☐ Yes ☐ No ☐ Work ☐ Auto ☐ Other: _____

When: _____ Nature of accident: _____

Did you require post-accident hospitalization: ☐ Yes ☐ No Did you lose workdays as a result: ☐ Yes ☐ No

How many: _____ Is/was insurance involved: ☐ Yes ☐ No Which company: _____

Attorney's name: _____ Claim number: _____

**Comments:** (*office use only*) _____

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