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	
☐	☐	Did you fall while learning to walk	
☐	☐	Spanking (how)	
☐	☐	Chair pulled out when sat down	
☐	☐	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: _____ Social Security#: _____

☐ 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: _____

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*) _____

_____

JOURNEY CHIROPRACTIC

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