

# Huntington Beach Chiropractic - Case History

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Hm Phone (\_\_\_\_\_) \_\_\_\_\_ Wk Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status            S            M            D            W            Spouse 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 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.

## ***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.

			Patient Comment If answer is Yes	Chiropractor's Comments
<b>1. Birth Process</b>				
<b>Yes</b>	<b>No</b>			
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
<b>2. Growth and Development</b>				
<b>Yes</b>	<b>No</b>			
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you a headbanger or rocker?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how)?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear/chin?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any other traumas? What? When?	_____	_____

# Huntington Beach Chiropractic - Case History (Pg 2)

Yes	No	<b>3. Current Health Habits</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/Do you drink any alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (Prescriptive/Non-prescriptive)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exersize regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares)?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping posture (Side/Stomach/Back)	_____	_____

## **Symptoms and Ill Health (Present State of Ill Health)**

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present Complaint (be brief) \_\_\_\_\_

Major \_\_\_\_\_

Pain or Problem started on \_\_\_\_\_

Pains are:       Sharp       Dull       Constant       Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is condition getting progressively worse? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Any home remedies? \_\_\_\_\_

Other symptoms:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Depression               | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Lights Bother Eyes       | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Loss of Memory           | <input type="checkbox"/> Cold Sweats     |
| <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Ears Ring                | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Fever                    | <input type="checkbox"/> Buzzing in Ears |

Have you been under drug and/or medical care? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

How Long? \_\_\_\_\_ Have you had surgery? \_\_\_\_\_ What? \_\_\_\_\_ When? \_\_\_\_\_

What side effects have you experienced form the drugs and/or surgery? \_\_\_\_\_

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other: _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **About Your Care**

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then we'll be able to begin a course of care that fits your health goals.