BEDFORD CHIROPRACTIC

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Case History

Name_____Date_____

Address_____

State_____ Zip_____

H. Phone (_____)_____ W. Phone (_____)_____

Cell Phone (_____)_____

Email _____

Date of Birth_____ Age_____ Gender M / F

Who may we thank for referring you to our office? _____

Social Security #_____

Occupation_____ Job Description_____

Employer_____ Address _____

Marital Status S M D W

Spouse Name_____

Spouse's Employer_____

Number of Children/Ages_____

Have you ever received Chiropractic Care? Yes No

Doctor's Name _____

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 and spine, which can result in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

Loss of Wellness

Let's begin at your birth, when you may have first damaged your nerve system/spine, lost wellness, and began your journey to your present health.

Please circle Yes (Y), No (N) or Don't Know (DK) for each of the following:

Regarding your Birth Process:				**Patient Comment**
Was the delivery long/difficult?	Y	N	DK	_____
Forceps or extraction used?	Y	N	DK	_____
Cesarean/ C-Section? _____	Y	N	DK	
Breach/ cephalic?	Y	N	DK	_____
Home birth?	Y	N	DK	_____

Hospital birth?	Y	N	DK	_____
Mother given drugs during delivery?	Y	N	DK	_____
Was labor induced?	Y	N	DK	_____

Regarding your Growth and Development **Patient Comment**

Were you breast fed? Y N DK
_____

Were you taught how
to care for your spine? Y N DK _____

Childhood illnesses? Y N DK _____

Ear infections/ Colic/ Asthma? Y N DK _____

Attention Deficit? Y N DK _____

Accidents? Y N DK _____

Drugs, including prescription? Y N DK _____

Surgery? Y N DK _____

Did you fall down stairs? Y N DK _____

Chair pulled out when sat down? Y N DK _____

Were you yanked by your arm? Y N DK _____

Did you have other traumas? Y N DK
_____

Did you ever break any bones? Y N DK _____

Current Health Habits

Did/do you smoke? Y N DK _____

Did/do you drink alcohol? Y N DK _____

Diet, do you eat healthy foods? Y N DK _____

Have you been in accidents/trauma? Y N DK _____

Have you had surgery and
organs removed/replaced? Y N DK _____

Drugs, including Prescription? Y N DK _____

Teeth problems? Y N DK _____

Eye problems? Y N DK
_____

Hearing problems? Y N DK _____

Exercise regularly? Y N DK _____

Do you sleep well? Y N DK _____

Did/do you have occupational stress? Y N DK
_____

Physical stress? Y N DK _____

Emotional/Mental stress? Y N DK _____

Hobbies/Sports injuries? Y N DK _____

Do you wear heel lifts, sole lifts,
inner soles, or arch supports? Y N DK
_____

Do you wear your seat belt?

Always Sometimes Never

Do you floss your teeth?

Always Sometimes Never

Do you take vitamin supplements?

Always Sometimes Never

In what position do you sleep? (check one)

___ side ___ stomach ___ back other (explain)_____

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms. Present Complaint/Reason for Seeking Care in this Office:

Primary_____Secondary_____

Pain or Problem started on _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other_____

Does this pain shoot, radiate, or travel in your body? Yes / No

Where? _____

Are you experiencing numbness or tingling in any area of your body? Yes / No

Where? _____

Are you experiencing throbbing, burning, cramps or swelling in any area of your body? Yes / No

Where? _____

What activities aggravate your condition/pain?

_____

Activities or movements that are painful to perform.

Sitting Standing Walking Bending Lying Down

What activities lessen your condition/pain?

_____

Is this condition worse during certain times of the day?

_____

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

Is this condition progressively getting worse? Yes No

_____

Please circle the intensity of your pain

(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other Doctors seen for this condition (please list Name of Drs.)

_____

Any home remedies? _____

How long has it been since you really felt good?

_____

Please mark any of the following that you have now or have experienced

AIDS/HIV Alcoholism Allergies Allergy Shots Anemia Anorexia

Appendicitis Arthritis Asthma Bleeding Disorders Breast Lump

Bronchitis Bulimia Cancer Chemical Dependency Chest Pains

Chicken Pox Constipation Depression Diabetes Diarrhea Dizziness

Emphysema Epilepsy Fatigue Fever Fractures Glaucoma Goiters

Gonorrhea Gout Headaches Heart Attack Heart Disease Hepatitis

Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol

Irritability Joint Swelling Kidney Disease Lights Bother Eyes

Liver Disease Loss of Balance Loss of Memory Loss of Smell or Taste

Measles Menstrual Cramps Migraine Headaches Miscarriage

Mononucleosis Multiple Sclerosis Mumps Neck Pain Neck Stiff

Nervousness Numbness in Hands or Arms Numbness in Legs or Feet

Osteoporosis Pacemaker Pain between Shoulders Shoulder Pain

Pain in Hands or Arms Pain in Legs or Feet Low Back Pain Painful Urination Parkinson's Disease Pinched Nerve Pneumonia Polio Prostate Problem

Prosthesis Psychiatric Care Rheumatoid Arthritis Rheumatic Fever

Scarlet Fever Shortness of Breath Sinus Problems Sleeping Problems

Stomach Upset Stroke Suicide Attempt Tension Thyroid Problems

Tonsillitis Tuberculosis Tumors, Growth Typhoid Fever Ulcers

Vaginal Infections Venereal Disease Weight Loss Whooping Cough

Other _____

Have you been under drug and medical care?

_____

What condition?

_____

Name of Dr.?

_____

What Medications are you taking?

_____

Reason for taking?

_____

How long?_____ Have you had surgery?_____

What?_____ When?_____

What side effects have you experienced from the drugs and surgery?

_____

Have you had X-rays in the last year?

_____

What for?

_____

Females Only – Date last Menstrual Period began on _____

Are you possibly Pregnant?_____

Is there a family History of:

Heart Disease Arthritis Cancer Diabetes

Other_____

Father's side Mother's side

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage (VSC Vertebral Subluxation Complex). This care often 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 you'll be able to begin a course of care that fits your goals.

Which of the following MOST CLOSELY matches your current health goals?

I am only interested in getting rid of my symptoms.

I am interested in fixing the underlying cause of my current health problems.

I am interested in being as healthy as I can be and take an active interest in my health.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian Signature_____ Date_____

Doctor's Signature _____Date_____