

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 have resulted in your lowered state of health. At your report of findings, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

PRESENT HEALTH: Are you presently affected by any of the following? (within past 3 months)

			O - OCCASIONAL	F - FREQUENT	C - CONSTANT				O - OCCASIONAL	F - FREQUENT	C - CONSTANT				O - OCCASIONAL	F - FREQUENT	C - CONSTANT				
MUSCLE AND JOINT	O	F	C	GENERAL SYMPTOMS	O	F	C	GASTROINTESTINAL	O	F	C	CARDIOVASCULAR	O	F	C						
Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever/Chills/Sweat ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Painful tailbone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous heart attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>							
Faulty posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation....	Yes <input type="checkbox"/>	No <input type="checkbox"/>							
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
STRESS SYMPTOMS			RESPIRATORY												FEMALES ONLY						
Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES, EARS, NOSE, THROAT						Painful menstruation	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm/blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Excessive flow	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Numbness or pins & needles in arms/hands, legs/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Irregular.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Ringing in ears.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Cramps or backache .	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Blurring of vision ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Abnormal discharge .	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				URINARY									Passed menopause .	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Loss of concentration/memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																Are you pregnant....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Irritable/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinussitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							Birth control pill	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting up at night to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
Decreased energy/fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
Tension.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>															

PAST HEALTH: Have you ever suffered from any of the following conditions?

		YES	NO			YES	NO			YES	NO			YES	NO
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems .	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Epileptic seizures	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>				
High blood pressure ..	<input type="checkbox"/>	<input type="checkbox"/>	Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>				
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>				
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>				

Please list any significant illness, operations, accidents, falls, or traumas

Date	Illness / Operation / Accident / Falls

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor.

If you read the above statement and consent to treatment.

Signature _____ Date Signed _____

Thank you for completing this form. We certainly hope that we can help you attain optimal health.