New Horizons Family Chiropractic

Phone: 815-464-0104   Website: www.nhfchiro.com

Patient Information

Name:____ Date:_________________________

Date of Birth____________________________ If you were referred, by whom?____________________

Address:____ City:________________ __________

State:_______ Zip:_________ Home Phone: (   )________________ Cell: (   )___________ ____

Work #: (   )______________ Occupation:______________________ Employer:____________________

Marital Status:___________________ Spouse's Name & Occupation:_______________________________

Number of Children and Ages:____

Have you ever received Chiropractic Care? ☐ Yes ☐ No - Reason for those visits?___________________

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

Nature of Accident:____ When?___________

Did you feel a popping or tearing in your back or neck from the accident? ☐ Yes ☐ No

Did you require hospitalization from the accident? ☐ Yes ☐ No

When?________________ Were X-Rays taken? ☐ 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 have 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.

Did you know that…

- Pain is only 10% of a nerves function ☐ Yes ☐ No
- Chiropractors see people that do not have pain ☐ Yes ☐ No
- The weight of a dime can decrease a nerves function by 60% ☐ Yes ☐ No
- The nervous system controls the function of your entire body ☐ Yes ☐ No

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About Your Care

Chiropractors provide three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (Subluxation). This care usually reduces or eliminates the symptoms. The next stage of care is **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractors offer 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 health goals.

Loss of Wellness

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

Your mother's pregnancy with you:

☐ Yes ☐ No Did your mother experience any slips or falls during pregnancy?______________________

Your Birth Process:

☐ Yes ☐ No Was your delivery long?____

☐ Yes ☐ No Was your delivery difficult?____

☐ Yes ☐ No Did the doctors need to use forceps?____

☐ Yes ☐ No Were you a caesarean?____

☐ Yes ☐ No Were you Breach/Cephalic?____

☐ Yes ☐ No Were you born at Home?____

☐ Yes ☐ No Were you born in a Hospital?____

☐ Yes ☐ No Was your mother's labor induced or given any drugs during delivery?_________________

Growth and Development (Childhood):

☐ Yes ☐ No Were you taught how to take care of your spine?_________________________________

☐ Yes ☐ No Did you ever fall out of bed when you were a kid?__________________________________

☐ Yes ☐ No Did you have any childhood sicknesses?____

☐ Yes ☐ No Were you in any accidents as a child? Car or Home_________________________________

☐ Yes ☐ No Did you have any surgeries as a child?____

☐ Yes ☐ No Did you take any drugs as a child?____

☐ Yes ☐ No Did you experience any child abuse?____

☐ Yes ☐ No Did you experience any severe spanking?____

☐ Yes ☐ No Did you have your ear or chin pulled as a child?___________________________________

☐ Yes ☐ No Did you ever have a chair pulled out from under you? (if so when?) ____________________

☐ Yes ☐ No Did you ever fall down the stairs as a child?_______________________________________

☐ Yes ☐ No Did you play sports/cheerleading? (List them) ______________________________________

☐ Yes ☐ No Did you have any other traumas as a child?_______________________________________

Loss of Whole Body Health (Currently)

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

☐ Yes ☐ No Did/do you smoke?____

☐ Yes ☐ No Did/do you drink alcohol?____

☐ Yes ☐ No Diet?____

☐ Yes ☐ No Have you ever been in any accidents recently?_____________________________________

☐ Yes ☐ No Do you currently take drugs? (Prescriptive/non-prescriptive) __________________________

☐ Yes ☐ No Do you have any teeth problems?____

☐ Yes ☐ No Do you have hearing problems?____

☐ Yes ☐ No Do you have any sleeping problems?____

☐ Yes ☐ No Did/do you have occupational stress?____

☐ Yes ☐ No Do you have physical stress?____

☐ Yes ☐ No Do you have emotional stress?____

☐ Yes ☐ No Do you have any injuries due to sports or hobbies?_________________________________

☐ Yes ☐ No List any other traumas or problems?____

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Symptoms and Ill Health

Years of untreated damage showed up as acute or chronic symptoms.

Other Symptoms:

☐ Headaches
☐ Neck Pain
☐ Neck Stiff
☐ Pins & Needles in Arms
☐ Numbness in Fingers
☐ Hands Cold
☐ Back Pain
☐ Pins & Needles in legs
☐ Feet Cold
☐ Numbness in Toes

☐ Face Flushed
☐ Lights Bother Eyes
☐ Loss of Memory
☐ Ears Ring/ Buzzing
☐ Loss of Smell
☐ Loss of Taste
☐ Dizziness
☐ Fainting
☐ Loss of Balance
☐ Cold Sweats

☐ Nervousness
☐ Tension
☐ Irritability
☐ Fatigue
☐ Chest Pain
☐ Shortness of Breath
☐ Stomach Upset
☐ Acid Reflux/ Gurd
☐ Constipation
☐ Diarrhea

☐ Sleeping Problems
☐ Depression

Female:

☐ **Pregnant**
☐ **Nursing**
☐ **Birth Control**
☐ **Painful Periods**
☐ **Irregular Cycles**

Present Complaint:

What is your current major complaint:____

When did the pain or problem start:____

Are the pains: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

What is the Intensity of your problem (1 being the lowest and 10 being the highest):

☐ 1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How often does the pain affect you: ☐ Daily ☐ 2-3 times a week ☐ sporadic

Is this condition worse at certain times of the day? ☐ morning ☐ afternoon ☐ evening ☐ sleep

Is this condition interfering with work?______ sleep?_____ routine?_____ other?_____

Is it getting progressively worse?____

Have you been under medical care recently for this problem?___________________________________

Have you been taking medication for this problem?____

Have you been taking any home remedies? (if so please list)_________________________________

Have you had surgery as an adult? ☐ Yes ☐ No

For what/when?____