

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? Yes No

Did you require hospitalization? Yes No

Where? _____ 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

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

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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 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.

Pregnancy:

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

Birth Process:

Yes No Was the delivery long? _____

Yes No Was the delivery difficult? _____

Yes No Forceps? _____

Yes No Caesarean? _____

Yes No Breach/Cephalic? _____

Yes No Home Birth? _____

Yes No Hospital Birth? _____

Yes No Was labor induced or given any drugs during delivery? _____

Growth and Development:

Yes No Where you taught how to take care of your spine? _____

Yes No Did you fall out of bed? _____

Yes No Did you have any childhood sicknesses? _____

Yes No Did you have any accidents? Car or Home _____

Yes No Did you have any surgeries? _____

Yes No Did you take any drugs? _____

Yes No Did you experience any child abuse? _____

Yes No Did you experience any severe spanking? _____

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- Yes No Did you have your ear or chin pulled? _____
- Yes No Chair pulled out when you sat down? _____
- Yes No Did you fall down the stairs? _____
- Yes No Where you yanked by your arm? _____
- Yes No Did you have any other traumas? _____

Loss of Whole Body Health

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

- Yes No Where you taught proper body movement and care? _____
- 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? _____
- Yes No Drugs? (Prescriptive/nonprescriptive)? _____
- Yes No Teeth problems? _____
- Yes No Hearing problems? _____
- Yes No Sleeping habits (nightmares)? _____
- Yes No Did/do have occupational stress? _____
- Yes No Physical stress? _____
- Yes No Mental stress? _____
- Yes No Hobbies/sports injuries? _____
- Yes No 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:

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

For Women: Pregnant Nursing Birth Control Painful Periods Irregular Cycles

Present Complaint:

Major Complaint: _____

Pain or problem started when: _____

Pains are: Sharp Dull Constant Intermittent

Intensity: 1 2 3 4 5 6 7 8 9 10

Frequency: 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? _____

Any home remedies? _____

Are you under drug or medical care? _____

What medications are you taking? _____

Have you had surgery? Yes No

For what/when? _____