lifehouse CHIROPRACTIC

## CLIENT INFORMATION

Name: _____

Date: _____ Gender: ☐ M ☐ F

Occupation: _____ Employer: _____ Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law

Number of Children and Ages: _____

Name of Spouse/Significant Other: _____

## 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.

## ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Conditioned Based Care, which corrects the most recent layer of Spinal and Neurological damage (Vertebral Subluxation Complex). This care usually reduces or eliminates the symptoms. Then begins Corrective 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 health goals.

## LOSS OF WELLNESS (BIRTH to 5 YRS)

At birth, your nerve system can be damaged; your wellness begins to decrease and the journey to ill health starts.

| Yes | No | | Patient Comment (if answer is yes) | Chiropractor's Comments |
|---|---|---|---|---|
| | | *Did your mother:* | | |
| ☐ | ☐ | Smoke or drink alcohol? | | |
| ☐ | ☐ | Have a proper diet? | | |
| ☐ | ☐ | Exercise through her pregnancy? | | |
| ☐ | ☐ | Experience any falls / injuries during pregnancy? | | |
| ☐ | ☐ | Experience any physical and/or mental abuse? | | |
| | | **2. Birth Process** | | |
| ☐ | ☐ | Was the delivery long? | | |
| ☐ | ☐ | Was the delivery difficult? | | |
| ☐ | ☐ | Forceps? | | |
| ☐ | ☐ | Caesarean? | | |
| ☐ | ☐ | Breach/cephalic? | | |
| ☐ | ☐ | Home Birth? | | |
| ☐ | ☐ | Hospital Birth? | | |
| ☐ | ☐ | Mother given drugs during delivery? | | |
| ☐ | ☐ | Was labour induced? | | |
| ☐ | ☐ | Were you jaundiced? | | |
| ☐ | ☐ | Did you experience feeding problems? | | |
| ☐ | ☐ | Did you have any respiratory problems? | | |
| ☐ | ☐ | Did you have any displaced/broken bones? | | |
| ☐ | ☐ | Other | | |

Patient Name _____

| Yes | No | 3. Growth and Development | Patient Comment (if answer is yes) | Chiropractor's Comments |
|---|---|---|---|---|
| ☐ | ☐ | Were you taught how to care for your spine? | | |
| ☐ | ☐ | Did you roll out of bed? | | |
| ☐ | ☐ | Were you a headbanger or rocker? | | |
| ☐ | ☐ | Were you breastfed? | | |
| ☐ | ☐ | Childhood sickness? | | |
| ☐ | ☐ | Accidents? | | |
| ☐ | ☐ | Surgery? | | |
| ☐ | ☐ | Drugs? | | |
| ☐ | ☐ | Did you fall while learning to walk? | | |
| ☐ | ☐ | Were you picked on by siblings? | | |
| ☐ | ☐ | Child abuse? | | |
| ☐ | ☐ | Spanking (how?) | | |
| ☐ | ☐ | Pulled ear/chin? | | |
| ☐ | ☐ | Other | | |
| ☐ | ☐ | Chair pulled out when sat down? | | |
| ☐ | ☐ | Did you fall down stairs? | | |
| ☐ | ☐ | Were you yanked by your arm? | | |
| ☐ | ☐ | Did you have other traumas? What? When? | | |

## LOSS OF WELLNESS (5 YRS to PRESENT)

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

| Yes | No | | Patient Comment (if answer is yes) | Chiropractor's Comments |
|---|---|---|---|---|
| ☐ | ☐ | Were you taught proper body movement and care? | | |
| ☐ | ☐ | Did/do you smoke? | | |
| ☐ | ☐ | Did/do you drink any alcohol? | | |
| ☐ | ☐ | Diet (Do you eat healthy foods)? | | |
| ☐ | ☐ | Have you had surgery and organs removed/ replaced? | | |
| ☐ | ☐ | Drugs? (Prescriptive or non-prescriptive) | | |
| ☐ | ☐ | Teeth problems? | | |
| ☐ | ☐ | Eye problems? | | |
| ☐ | ☐ | Hearing problems? | | |
| ☐ | ☐ | Sleeping habits (nightmares)? | | |
| ☐ | ☐ | Did/do you have occupational stress? | | |
| ☐ | ☐ | Physical stress? | | |
| ☐ | ☐ | Mental stress? | | |
| ☐ | ☐ | Other traumas or problems? | | |

## FAMILY HISTORY

Father's Side

☐ Heart Disease
☐ Arthritis
☐ Cancer
☐ Diabetes
Other:

Mother's Side

☐ Heart Disease
☐ Arthritis
☐ Cancer
☐ Diabetes
Other:

Patient Name _____

# ADDITIONAL SOURCES OF SPINAL STRESS

To help us determine the cause of your problem, please indicate, on this page, potential sources of spinal trauma.

Primary Daily Activities:
☐ sitting ☐ standing ☐ walking ☐ desk work ☐ telephone ☐ driving ☐ manual/repetitive work ☐ lifting

Sports & Leisure: Were you, or are you active in any sports? ☐ Yes ☐ No

Describe: _____

Have you been hurt or injured in any of these activities: ☐ Yes ☐ No

Describe: _____

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident, or near collision?

☐ Yes ☐ No If yes, please indicate approximate dates and severity: _____

_____

Have you ever been knocked unconscious? ☐ Yes ☐ No _____

Have you ever used crutches, a walker or cane? ☐ Yes ☐ No _____

Have you had any broken bones? ☐ Yes ☐ No _____

Have you had any impacts, falls or jobs that you feel specifically may have injured your spine? ☐ Yes ☐ No _____

_____

Sprains, strains, dislocations, what and when?

_____

Have you ever been hospitalized for any other reason? ☐ Yes ☐ No _____

History of Chemical and Personal Stress

Health Habits:

| | Heavy | Moderate | Light | None |
|---|---|---|---|---|
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Recreational Drugs | ☐ | ☐ | ☐ | ☐ |
| Prescription Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |
| **Personal Stress Levels** | | | | |
| Past | ☐ | ☐ | ☐ | ☐ |
| Present | ☐ | ☐ | ☐ | ☐ |

Patient Name _____

Medications I am presently taking:

- ☐ Painkillers _____
- ☐ Anti-Inflammatories _____
- ☐ Muscle relaxants _____
- ☐ Blood pressure medication _____
- ☐ Stimulants, Anti-depressants _____
- ☐ Tranquilizers, Anti-anxiety _____
- ☐ Blood thinners _____
- ☐ Birth control pills _____
- ☐ Natural Supplements & Remedies _____
- ☐ Other _____

## SYMPTOMS & ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Please check each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, or referral to another practitioner.

***Past – Present General***

- ☐ Allergy
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Anxiety/Depression
- ☐ Memory loss
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Epilepsy
- ☐ Hyperactivity
- ☐ Balance problems
- ☐ Tension/Irritability
- ☐ Stiff neck

***Past – Present Numbness/ pain:***

- ☐ Shoulders
- ☐ Upper arms
- ☐ Hands
- ☐ Legs
- ☐ Feet

***Past – Present Gastro-Intestinal***

- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Gall Bladder problem
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Ulcers
- ☐ Stomach upset

***Past – Present Muscle & Joint***

- ☐ Arthritis
- ☐ Hernia
- ☐ Low back pain
- ☐ Neck pain
- ☐ Chronic Fatigue
- ☐ Poor posture
- ☐ Swollen joints
- ☐ Gout
- ☐ Polio
- ☐ Fibromyalgia
- ☐ Pain between shoulder blades

***Past – Present Eyes/Ears/Nose***

- ☐ Frequent Colds
- ☐ Crossed Eyes
- ☐ Deafness
- ☐ Ear infections
- ☐ Ringing in Ears
- ☐ Eye pain
- ☐ Vision problems
- ☐ Nasal obstruction
- ☐ Sinus infection

***Past – Present Genito-Urinary***

- ☐ Bed-wetting
- ☐ Painful urination
- ☐ Blood in Urine
- ☐ Venereal Disease

***Past – Present Women Only***

- ☐ Menstrual Cramps
- ☐ Excessive Menses
- ☐ Irregular cycles
- ☐ Hot Flashes
- ☐ PMS
- ☐ Pregnant

***Past – Present Cardio-Vascular***

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Irregular heart beat
- ☐ Ankle swelling
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Cold hands or feet
- ☐ Numbness
- ☐ Flushed face

***Past – Present Respiratory***

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Irregular breathing
- ☐ Wheezing
- ☐ Emphysema
- ☐ Asthma

***Past – Present Other***

- ☐ Dental issues

***Past – Present Men Only***

- ☐ Prostate trouble

***Other*** (not listed) _____

**Patient Name** _____

## PURPOSE OF THIS APPOINTMENT/PRESENT COMPLAINT

Describe the purpose of this visit: _____

Is it related to: ☐ Work ☐ Stress ☐ Sports ☐ Auto ☐ Fall ☐ Chronic Pain ☐ Repetitive Trauma ☐ Check-up

☐ Other, please explain: _____

*(For a specific chief complaint, please complete the following section)*

How long have you had this condition? _____ Have you had it in the past, when? _____

What activities aggravate your condition? _____

Has this condition ☐ gotten worse ☐ stayed constant ☐ comes and goes?

Does this condition interfere with ☐ work ☐ sleep ☐ daily routines ☐ childcare responsibilities ☐ sports

Have you seen any other health care providers for diagnosis or management of this condition or other health issues? ☐ Yes ☐ No

Practitioner's Name _____ Practitioner's Name _____

Type of Care _____ Type of Care _____

Date _____ Results _____ Date _____ Results _____

Are you seeking chiropractic care ☐ as primary intervention ☐ in conjunction with other interventions ☐ as a last resort

Family Doctor _____

Address _____ Phone Number _____

_____ Approximate Date of Last Visit _____

## EXPERIENCE WITH CHIROPRACTIC CARE

Who referred you to this office? _____

Have you ever been adjusted by another Chiropractor? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Chiropractor's name: _____ Did your family receive chiropractic care? ☐ Yes ☐ No ☐ N/A

Reasons for those visits? _____

Approximate date of last visit: _____

## FOR OFFICE USE ONLY