SCOTT CHIROPRACTIC

Case History

Date:_____

Name:_____

Address:_____City/State/Zip _____

Occupation:_____ Home Phone: _____ Cell Phone:_____

Date of Birth:_____ Age: _____ ❑ M ❑ F Marital Status: _____ No. of Children: _____

Social Security Number: _____ Insurance:_____

How did you hear about our office? _____

Please provide your email address if you would like to be included in our newsletter distribution:

Email Address: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

Have you ever had your spine or nervous system examined professionally? ❑ Yes ❑ No

If yes, when and by whom? _____

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? ❑ Yes ❑ No

If yes, when was your last visit?_____

For how long were you receiving chiropractic adjustments? _____

How often did you go? _____

If you stopped, why did you stop going?_____

Do you know what type of adjustments the chiropractor performed, or what technique(s) or method(s) he or she used?

_____

Were you pleased with his or her service? ❑ Yes ❑ No

Does your immediate family receive chiropractic adjustments? ❑ Yes ❑ No

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL or EMOTIONAL in nature.

Do you know what a vertebral subluxation is? ❑ Yes ❑ No

GENERAL PHYSICAL TRAUMA

Have you ever had any impacts, falls or jolts that you feel specifically may have injured your spine? ❑ Yes ❑ No

Comments: _____

Have you ever broken any bones? ❑ Yes ❑ No

Comments: _____

Have you had extensive dental work performed? ❑ Yes ❑ No

Orthodontic work? ❑ Yes ❑ No

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During the day I: ❑ Sit ❑ Stand ❑ Walk ❑ Drive

During the day I do: ❑ Desk Work ❑ Phone Work ❑ Mechanical Work ❑ Heavy Lifting

I exercise: ❑ Daily ❑ Weekly ❑ Monthly

I sleep: ❑ 0-4 hrs ❑ 4-8 hrs ❑ 8 or more hrs

SPORTS AND LEISURE

Were you, or are you active in any particular sport or work-out program? ❑ Yes ❑ No

Which one(s): _____

Have you been hurt in any of these activities? ❑ Yes ❑ No

Comments: _____

Do you read for prolonged periods? ❑ Yes ❑ No

Do you play a musical instrument? ❑ Yes ❑ No

Do you have a particular position for watching television? ❑ Yes ❑ No

Comments: _____

I wear: ❑ Glasses ❑ Bifocals ❑ Contact Lenses

AUTOMOTIVE ACCIDENTS

Have you (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision/near collision?

Please list approximate dates and severity (mild, moderate or extreme)?

Automobile/bicycle/motorcycle (other): _____

_____

_____

_____

MEDICAL TREATMENT

Have you ever been hospitalized? ❑ Yes ❑ No

If yes, what procedure(s) were performed? _____

_____

_____

Please describe any surgeries? _____

_____

_____

Do you still have all your body parts? _____

_____

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Have you had:

- ❑ Acupuncture
- ❑ Chemotherapy
- ❑ Colon Therapy
- ❑ Bone in a Cast or Immobilized
- ❑ Diagnostic X-Rays
- ❑ Heel Lift
- ❑ Massage/Body Work
- ❑ MRI/CT Scan
- ❑ Physiotherapy
- ❑ Spinal Brace
- ❑ Spinal Injections
- ❑ Traction

GENERAL CHEMICAL TRAUMA

Are you now taking any drugs (prescription or over-the-counter) regularly? Please list: _____

_____

Are these drugs being prescribed by a physician? _____ Last visit: _____

Were you previously taking any medication regularly? _____

_____

Are you currently taking any vitamins or herbs? If so, what kind: _____

_____

Do you work with any chemical, fume, dust, powder, smoke for prolonged periods? _____

_____

OTHER

Do you consume any of the following? (Mark: D=Daily, W=Weekly, N=Never)

Alcohol _____	Coffee _____	Tobacco _____	Eggs _____
Vegetables _____	Fruit _____	Whole Grains _____	Dairy (milk products) _____
Beef _____	Poultry _____	Fish _____	Organic Foods _____

Have you experienced an emotional trauma within the last two years? If yes, please explain: _____

_____

_____

Have you ever or are you now enrolled in a counseling or group program? If yes, please explain: _____

_____

_____

If you consider yourself ill, why do you feel you are ill? _____

_____

_____

If you consider yourself well, why do you feel you are well? _____

_____

_____

Is there anything else which may help to better understand you which has not be discussed? _____

_____

_____