Blackman Family Chiropractic

Healthier People, Healthier Planet

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Case History

NAME_____ DATE_____
If you were referred, by whom? _____
Have you ever received Chiropractic Care? ❒ YES ❒ NO If so, where?_____
Reason for those visits_____ Approximate Date of last visit_____
Number of Children and ages_____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health. This case history will uncover the layers of damage, especially to your nerve system, that 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.

Were you aware that...

- Doctors of Chiropractic work with the nervous system? ❒ YES ❒ NO
- The nervous system controls all bodily functions and systems? ❒ YES ❒ NO
- Chiropractic is the largest natural healing profession in the world? ❒ YES ❒ NO
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❒ YES ❒ NO

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

	NO	YES	PATIENT COMMENT If answer is YES	CHIROPRACTOR'S Comments
1. BIRTH PROCESS				
Did your mother experience any falls, injuries, or abuse during pregnancy?	____	____	_____	_____
Was the delivery long?	____	____	_____	_____
Was the delivery difficult?	____	____	_____	_____
Forceps?	____	____	_____	_____
Cesarean?	____	____	_____	_____
Breach?	____	____	_____	_____
Home birth?	____	____	_____	_____
Hospital birth?	____	____	_____	_____
Mother given drugs during delivery?	____	____	_____	_____
Was labor induced?	____	____	_____	_____
2. GROWTH AND DEVELOPMENT (BIRTH THROUGH TEENAGE YEARS)				
Were you taught how to care for your spine?	____	____	_____	_____
Did you fall out of bed?	____	____	_____	_____
Did you fall while learning to walk?	____	____	_____	_____
Did you have childhood sickness?	____	____	_____	_____
Did you fall down stairs?	____	____	_____	_____
Chair pulled out when sat down?	____	____	_____	_____
Did you have accidents?	____	____	_____	_____
Did you have surgery?	____	____	_____	_____
Did you take medication/drugs?	____	____	_____	_____
Were you picked on by siblings?	____	____	_____	_____
Did you experience child abuse?	____	____	_____	_____
Did you experience severe spanking?	____	____	_____	_____
Did you have your ear/chin pulled?	____	____	_____	_____
Were you yanked by your arm?	____	____	_____	_____

Loss of Whole Body Health

As layers of damage due to physical, chemical, and mental stresses increased, you probably began to experience symptoms and random bouts of sickness.

3. HEALTH HABITS AND STRESSES (CHILDHOOD TO PRESENT)

	NO	YES	PATIENT COMMENT If answer is YES	CHIROPRACTOR'S Comments
Did/ do you smoke?	_____	_____	_____	_____
Did/ do you drink any alcohol?	_____	_____	_____	_____
Diet (Do you eat healthy foods?)	_____	_____	_____	_____
Have you been in accidents?	_____	_____	_____	_____
Have you had surgery & organs removed/ replaced?	_____	_____	_____	_____
Did/ do you take drugs prescriptive or non-prescriptive?	_____	_____	_____	_____
Did/ do you have occupational stress?	_____	_____	_____	_____
Did/ do you have physical stress?	_____	_____	_____	_____
Did/ do you have mental stress?	_____	_____	_____	_____
Did/ do you have sports injuries?	_____	_____	_____	_____

Primary Reason for Consulting this Office

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint_____
When did this health challenge begin? _____ What were you doing? _____

Pains are: ❒ SHARP ❒ DULL ❒ CONSTANT ❒ INTERMITTENT Is this condition getting progressively worse? ❒ YES ❒ NO

Frequency: ❒ DAILY ❒ 2-3 TIMES WEEKLY ❒ SPORADIC

Is this condition worse at certain times of the day? ❒ Morning ❒ Afternoon ❒ Evening ❒ During sleep

Does this condition interfering with: ❒ Work ❒ Sleep ❒ Routine ❒ Other_____
Other doctors seen for this_____
Are you using any home remedies?_____

OTHER SYMPTOMS Please check each of symptoms if you have them now or have had them in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.

❒ HEADACHES	❒ FEVER	❒ FAINTING	❒ TENSION	**FOR WOMEN:**
❒ NECK PAIN	❒ FACE FLUSHED	❒ SLEEPING PROBLEMS	❒ IRRITABILITY	❒ PREGNANT
❒ NECK STIFF	❒ DIZZINESS	❒ SHORTNESS OF BREATH	❒ FATIGUE	❒ NURSING
❒ UPPER BACK PAIN	❒ LOSS OF BALANCE	❒ CHEST PAINS	❒ DEPRESSION	❒ BIRTH CONTROL
❒ MID-BACK PAIN	❒ LIGHTS BOTHER EYES	❒ LOSS OF MEMORY	❒ ANXIETY	❒ PAINFUL PERIODS
❒ LOW BACK PAIN	❒ SINUS PROBLEMS	❒ LOSS OF SMELL	❒ STOMACH UPSET	❒ IRREGULAR CYCLE
❒ NUMBNESS OR PAIN IN ARMS/HANDS/FINGERS	❒ BUZZING OR RINGING IN EARS	❒ LOSS OF TASTE	❒ DIARRHEA	
		❒ COLD SWEATS	❒ CONSTIPATION	
❒ NUMBNESS OR PAIN IN LEGS/FEET/TOES	❒ COLD FEET/HANDS	❒ ASTHMA	❒ ALLERGIES	

Have you been under medical care recently or for this problem?_____
Have you been taking prescriptive or non-prescriptive drugs? _____
Have you had surgery? ❒ YES ❒ NO Any side effects from drugs or surgery?_____

Is there a family history of:	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

Patient Signature_____Date_____

Doctor Signature_____Date_____