

Nottingham Place Chiropractic Clinic

Case History

Name:		Health Card Number:	Version Code:	Expiry Date:
Address:		City:	Postal Code:	
Home Phone: () ()	Work Phone: () ()	Cell Phone: () ()	Date of Birth (d,m,y)	Age: Sex <input type="checkbox"/> M <input type="checkbox"/> F
E-mail Address:		Name, Number and Relationship of Emergency Contact:		
Occupation:		Employer:		
Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed		Spouse's Name:		Spouse's Occupation:
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No	What are their names/ages?			
Who can we thank for referring you to this office?	Have you ever received chiropractic care before? <input type="checkbox"/> Yes <input type="checkbox"/> No When?		Spinal x-rays available? <input type="checkbox"/> Yes <input type="checkbox"/> No When taken?	

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 nervous 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.

Loss of Wellness

1. YOUR BIRTH PROCESS

Was the delivery Long Difficult Forceps Vacuum Extraction Caesarean Breech

2. SPINAL TRAUMA DURING GROWTH AND DEVELOPMENT

	YES	NO	COMMENTS
Fall off a bicycle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you fall out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rough play with siblings/friends?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you fall while learning to walk?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Victim of child abuse?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you spanked?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you pulled by your ear or chin?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chair pulled out from under you?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you fall down the stairs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you yanked by your arm?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have other trauma(s)? What? When?	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. ACCIDENT HISTORY

The vast majority of our patients have experienced literally dozens of impacts that can adversely affect their spine and nervous system and eventually result in symptoms.

CAR ACCIDENTS

The research tells us that we experience one car accident each decade of our life and that our spine travels two to four times the speed of vehicle impact.

3. CONTINUED

MOST RECENT CAR ACCIDENT:

_____years/months ago

I was the Driver Passenger

Front Side Rear Impact

Damage to vehicle \$0 - \$1000 \$1000 - \$5000 \$5000+

Approx. speed of impact _____kms/hr

Loss of consciousness Yes No

Seatbelt worn Yes No

Hospitalization Yes No

Injuries sustained _____

Family members in car Yes No

Chiropractic care received Yes No

PREVIOUS ACCIDENT:

_____years/months ago

I was the Driver Passenger

Front Side Rear Impact

Damage to vehicle \$0 - \$1000 \$1000 - \$5000 \$5000+

Approx. speed of impact _____kms/hr

Loss of consciousness Yes No

Seatbelt worn Yes No

Hospitalization Yes No

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Injuries sustained _____

Family members in car Yes No

Chiropractic care received Yes No

3. CONTINUED

SLIPS, FALLS AND SPORTING INJURIES

Please indicate any significant falls or slips that have occurred at either home or at work.

Fallen from height Yes No

Slipped/Fallen on ice Yes No

Slipped/Fallen down stairs Yes No

Stairs were concrete wood carpeted other _____

Other Falls/slips: _____

Please briefly list any significant sporting injuries: _____

4. **WORK HISTORY (REPETITIVE AND/OR MICRO-TRAUMA)**

My current occupation involves:

Lifting (average weight lifted _____)

Overhead lifting Yes No

Sitting _____ hours per day

Computer work _____ hours per day

Standing _____ hours per day Carpet Concrete Rubber Mats

Driving _____ hours per day

Repetitive work: Bending Twisting Lifting Other _____

Assembly work: Yes No Fine movements involved Yes No

Previous Occupation:

Lifting (average weight lifted _____)

Overhead lifting Yes No

Sitting _____ hours per day

Computer work _____ hours per day

Standing _____ hours per day Carpet Concrete Rubber Mats

Driving _____ hours per day

Repetitive work: Bending Twisting Lifting Other _____

Assembly work: Yes No Fine movements involved Yes No

5. **CURRENT HEALTH HABITS**

YES NO

Did/do smoke? Quantity _____

Did/do drink any alcohol? Quantity _____

Do you eat healthy food?

Have you had surgery?

Drugs? (Prescriptive or non prescriptive)

Grinding teeth or jaw problems?

Exercise regularly?

Do you have occupational stress?

Physical stress?

Mental stress?

Sleeping posture side stomach back

Number of pillows _____

Present State of Ill Health

FINALLY, THE YEARS OF CONTINUING DAMAGE SHOWED UP AS ACUTE OR CHRONIC SYMPTOMS

Present complaint (be brief) _____

Pain or problem started when? _____

Pains are: Sharp Dull Constant Intermittent

Is the condition worse during certain times of the day? _____

Is this condition interfering with work? Sleep? Family/Social Life? Other? _____

Is condition getting progressively worse? Yes No Other Doctors seen? _____

Any home remedies? _____

What medications are you taking? _____

OTHER SYMPTOMS: *present now or within past few years*

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain/Pins & Needles in Legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pain/Pins & Needles in Arms | <input type="checkbox"/> Allergies/Asthma |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Tension/Stress | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Ear Rings or Buzzes | <input type="checkbox"/> Fever | <input type="checkbox"/> Bladder/Bowel Problems |
| <input type="checkbox"/> Loss of Smell or Taste | <input type="checkbox"/> Significant Weight Loss | <input type="checkbox"/> Stroke |

WHICH WOULD BEST DESCRIBE YOUR CURRENT LEVEL OF HEALTH?

(Constant Illness) 1 2 3 4 5 6 7 8 9 10 (Perfect health)

FOR WOMEN: Are you pregnant? YES NO MAYBE Date of last menstrual cycle? _____

Number of Pregnancies _____ Number of Births _____ Number of Epidurals _____ Number of C-Sections _____

Forcep Assisted _____ Vacuum Extractions _____

IS THERE A FAMILY HISTORY OF:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Concerns: _____

Confidential: Please make the doctor aware if you are HIV positive or if you have any other communicable disease i.e. TB, Hepatitis

Signature: _____ Date: _____