



43059 Seven Mile Road · Northville, MI 48167 · 248.449.1630 · Fax 248.449.1558

CASE HISTORY

Please allow our staff to photocopy your driver's license & insurance information. All information will be confidential.

NAME _____ DATE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE(____) _____ CELL PHONE(____) _____
 EMAIL _____
 BIRTH DATE _____ (AGE _____) MARITAL STATUS: S M D W
 REFERRED BY _____
 OCCUPATION _____ EMPLOYER _____
 EMERGENCY CONTACT _____ PHONE# _____
 HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____ YES ____ NO

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 result 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

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

1. BIRTH PROCESS

Patient Comments

Dr's Comments

<input type="checkbox"/> Mother had an injury/fall when pregnant	_____	_____
<input type="checkbox"/> Mother given drugs during delivery	_____	_____
<input type="checkbox"/> Delivery was long or difficult	_____	_____
<input type="checkbox"/> Forceps/Vacuum used in delivery	_____	_____
<input type="checkbox"/> Labor was induced	_____	_____
<input type="checkbox"/> Cesarean Birth	_____	_____
<input type="checkbox"/> Breach Birth	_____	_____
<input type="checkbox"/> Home birth	_____	_____
<input type="checkbox"/> Hospital birth	_____	_____

2. GROWTH AND DEVELOPMENT (Birth - Teenager)

<input type="checkbox"/> Taught how to care for your spine	_____	_____
<input type="checkbox"/> Fell out of bed	_____	_____
<input type="checkbox"/> Had growing pains	_____	_____
<input type="checkbox"/> Had surgery	_____	_____
<input type="checkbox"/> Did you take drugs	_____	_____
<input type="checkbox"/> Experienced child abuse	_____	_____
<input type="checkbox"/> Experienced severe spanking	_____	_____
<input type="checkbox"/> Ear/chin pulled	_____	_____
<input type="checkbox"/> Fell down stairs	_____	_____
<input type="checkbox"/> Chair pulled out when sat down	_____	_____
<input type="checkbox"/> Yanked by your arm	_____	_____
<input type="checkbox"/> Bicycle/car/ATV accidents	_____	_____
<input type="checkbox"/> Did you have childhood sickness	_____	_____



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3. CURRENT HEALTH **Patient Comments** **Dr's Comments**

<input type="checkbox"/> Did/do you smoke	_____	_____
<input type="checkbox"/> Did/do you drink any alcohol	_____	_____
<input type="checkbox"/> Do you eat healthy foods	_____	_____
<input type="checkbox"/> Do you exercise regularly	_____	_____
<input type="checkbox"/> Have you had surgery	_____	_____
<input type="checkbox"/> Broken bones or dislocations	_____	_____
<input type="checkbox"/> Organs removed/ operated on	_____	_____
<input type="checkbox"/> Did/do you take prescriptive or Non-prescriptive drugs	_____	_____
<input type="checkbox"/> Did/do you have occupational stress	_____	_____
<input type="checkbox"/> Did/do you have physical stress	_____	_____
<input type="checkbox"/> Did/do you have mental stress	_____	_____
<input type="checkbox"/> Did/do you have sports injuries?	_____	_____

PRIMARY REASON FOR CONSULTING OFFICE

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

Present complaint _____

Pain or problem started on _____

Pains are: SHARP DULL CONSTANT INTERMITTENT

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

Frequency: Daily 2-3 times weekly Sporadic

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

Is this condition getting progressively worse? _____ Other doctors seen for this _____

Are you using any home remedies? _____

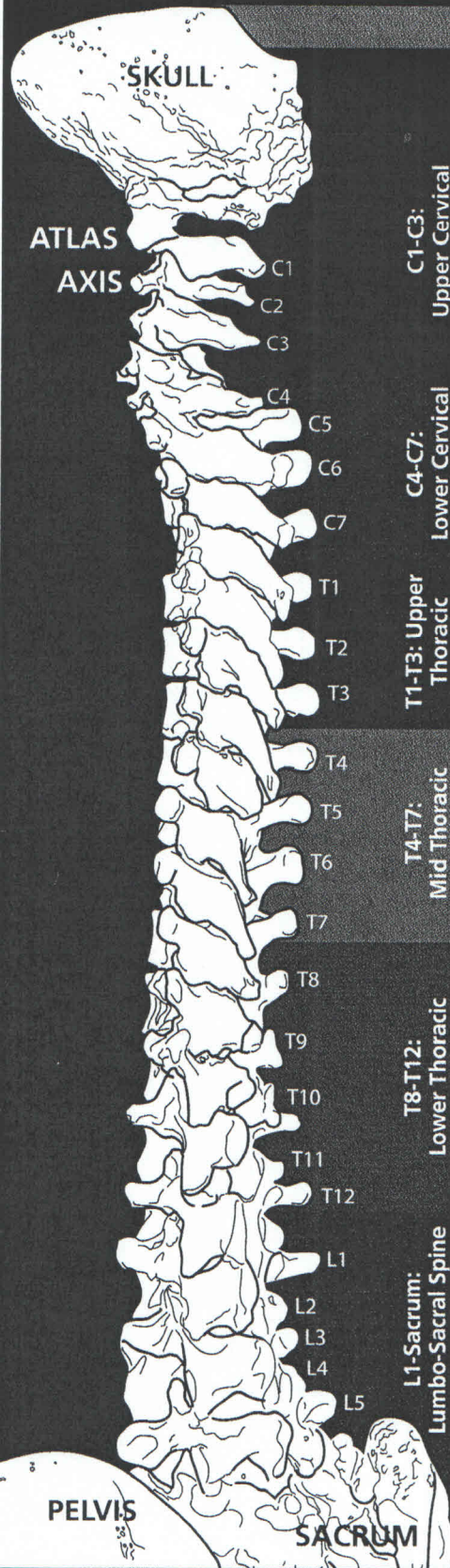
Have you been taking prescriptive or non-prescriptive drugs? _____

Any side effects from the drugs? _____

On the next page, please check the boxes on the right hand side under "EFFECT" of any health condition you may be experiencing now or in the past.

The Effects of Subluxation (Nerve Interference)

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY



CAUSE		EFFECT
Primary & Secondary Functions	Tissues, Organs & Glands	Possible Symptoms
C1-C3: Upper Cervical <ul style="list-style-type: none"> Autonomic Nervous System ENT System Vision, Balance & Coordination Speech Immune System Digestive System 	<ul style="list-style-type: none"> Vagus Nerve (aka Brake Pedal) Brainstem Inner / Middle Ear Sinuses Pituitary Gland Face, Jaw & Teeth Eyes 	<ul style="list-style-type: none"> Colic & Excessive Crying Headaches & Migraines Anxiety & Stress ADD / ADHD Sensory & Spectrum Epilepsy & Seizures Speech Issues Difficulty Sleeping Chronic Fatigue Depression Ear & Sinus Infections Allergies & Congestion Immune Deficiencies Balance & Coordination Vertigo & Dizziness Vision & Hearing Issues Focus & Memory Issues High Blood Pressure Reflux / GERD
C4-C7: Lower Cervical <ul style="list-style-type: none"> Nerve Supply to Shoulders, Arms & Hands Sympathetic Nucleus ENT System Metabolism 	<ul style="list-style-type: none"> Inner Ear, Tonsils & Throat Vocal Cords Neck & Shoulder Muscles Nerves to Arms, Wrists & Hands Thyroid Gland 	<ul style="list-style-type: none"> Ear & Sinus Infections Allergies & Congestion Sore Throat & Strep Swollen Tonsils & Adenoids Croup & Cough Headaches & Migraines Stiff Neck & Shoulders Pain, Numbness & Tingling in Arms to Hands Speech Issues Poor Metabolism & Weight Control
T1-T3: Upper Thoracic <ul style="list-style-type: none"> Upper GI Respiratory System Cardiac Function 	<ul style="list-style-type: none"> Upper Back & Shoulders Esophagus & Upper GI Lungs, Bronchi & Upper Respiratory Cardiac / Heart Chest / Sternum 	<ul style="list-style-type: none"> Stiff Neck & Shoulders Reflux / GERD Chronic Colds & Cough Bronchitis & Pneumonia Asthma Functional Heart Conditions
T4-T7: Mid Thoracic <ul style="list-style-type: none"> Major Digestive Center Detox & Immunity 	<ul style="list-style-type: none"> Gallbladder Liver Stomach Pancreas Spleen Middle Back & Shoulders 	<ul style="list-style-type: none"> Gallbladder Pain / Issues Jaundice Fever Indigestion / Heartburn Stomach Pains Ulcers Blood Sugar Problems Immune Deficiency
T8-T12: Lower Thoracic <ul style="list-style-type: none"> Stress Response Filtration & Elimination Gut & Digestion Hormonal Control 	<ul style="list-style-type: none"> Adrenal Glands Kidneys Ureters Small Intestine Reproductive Organs 	<ul style="list-style-type: none"> Excess Stress & Cortisol Poor Metabolism Chronic Fatigue Hyperactivity & Anxiety Behavior Issues Cramps & Menstrual Problems Kidney Problems / Stones Allergies & Eczema Skin Conditions / Rash Bedwetting Gas Pain & Bloating Infertility
L1-Sacrum: Lumbo-Sacral Spine <ul style="list-style-type: none"> Lower G.I. (Absorption & Motility) Gut-Immune System Major Hormonal Control 	<ul style="list-style-type: none"> Large Intestine Bladder Ovaries & Uterus Prostate Gland Lymph Circulation Lower Back & Pelvic Muscles Nerves to Legs, Knees & Feet Parasympathetic Plexus (aka Brake Pedal) 	<ul style="list-style-type: none"> Constipation & Gas Crohn's, Colitis & IBS Diarrhea Bladder Problems & Bedwetting Difficult, Painful & Excessive Urination Cramps & Menstrual Problems Cysts & Endometriosis Infertility Impotency Hemorrhoids Sciatica & Radiating Pain Lumbopelvic / SI Joint Pain IT Band & Hamstring Tightness Disc Degeneration Leg Weakness & Cramps Poor Circulation & Cold Feet Knee, Ankle & Foot Pain Weak Ankles & Arches Immune Deficiency Gluten & Casein Intolerance

When tension and stress build up in an area of the spine, it creates interference and "overloads" the nerve or nerves nearby, creating what is known as a subluxation. This subluxation acts similar to a blown fuse in your house. When a fuse blows in your home, certain areas or appliances may not function until that power is restored. Similarly, by finding and correcting any subluxations in your spine, specific chiropractic adjustments help restore power and function to those parts of your body.



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Family Health Questionnaire

This is an additional questionnaire for those willing to radically improve their life. As your family chiropractor, I want to help you reach greater health and well-being according to your specific needs.

"True health is a state of optimal physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity."- Dorland's Medical Dictionary

Please rate your current Physical Health

1	2	3	4	5	6	7	8	9	10
Miserable				Symptomatic				Optimal	

Please rate your current Mental Health

1	2	3	4	5	6	7	8	9	10
Suicidal			Fatigued/Stressed				Peaceful		

Please rate your current Social/Relationship Health

1	2	3	4	5	6	7	8	9	10
Secluded			Irritable towards others				Loving		

Please rate your current Spiritual Health

1	2	3	4	5	6	7	8	9	10
No Spirituality				On Purpose			Intimately Connected		

Does your current health status prevent you from doing any of the following?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Recreation/sports | <input type="checkbox"/> Performing at my best | <input type="checkbox"/> Socializing |
| <input type="checkbox"/> Family fun | <input type="checkbox"/> Hobbies | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Traveling | <input type="checkbox"/> School work/Job | <input type="checkbox"/> Other _____ |

Please check all that apply to you...

- I am interested in relieving my symptoms only (short-term relief care)
- I am interested in short-term relief care and long-term reconstructive care
- I feel great now, but I want to include Chiropractic in my Wellness regimen to be and perform at my best.
- I am interested in having my entire family (significant other and/or children) scheduled for a Chiropractic health screening and examination.