Adjusted Health CHIROPRACTIC
14989 S. DIXIE HWY, MONROE, MI 48161
www.adjustedhealthchiro.com (734) 244-4285

PATIENT INFORMATION

Date: _____

NAME: _____DATE OF BIRTH: _____AGE_____
CELL PHONE #: _____ HOME PHONE # _____
EMAIL ADDRESS:_____ REFERRED BY: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____
OCCUPATION: _____ EMPLOYER: _____
MARITIAL STATUS: S M D W SPOUSES NAME: _____
SPOUSES OCCUPATION: _____ NUMBER OF CHILDREN AND AGES: _____
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE IN THE PAST? _____ YES _____ NO
INSURANCE CARRIER _____POLICY HOLDER NAME_____DOB _____
POLICY ID # _____ GROUP # _____

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 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

We will begin at birth, when your nerve system is often first damaged, causing a loss of your wellness and beginning the journey toward ill health.

(Birth – Age 5)

YES	NO	**1. BIRTH PROCESS**
___	___	Hospital birth?
___	___	Was the delivery long?
___	___	Cesarean?
___	___	Breach
___	___	Forceps used?

Yes	**NO**	**2. GROWTH AND DEVELOPMENT**
___	___	Were you taught how to care for your spine?
___	___	Childhood sickness?
___	___	Take any drugs/medications?

(AGE 5 - PRESENT)

YES	NO	**3. LOSS OF WHOLE-BODY HEALTH**
___	___	Did you/Do you smoke?
___	___	Did you/Do you drink alcohol?
___	___	Did you/Do you eat healthy foods?
___	___	Were you taught about proper posture?
___	___	Emotional stress?
___	___	Occupational stress?
___	___	Sports injuries?

___	___	Did/Do you take any drugs (Prescription or Not)
___	___	Do you exercise regularly?
___	___	Physical stress?
___	___	Have you been in any accident?
___	___	Any surgeries? (Back or other location)

Additional patient comments (details of accident(s)/Surgeries etc.):

_____

_____

LOSS OF HEALTH SYMPTOMS

Years of untreated damage to the nerve system can show up as acute or chronic symptoms.

OTHER SYMPTOMS:

___ HEADACHES	___ NECK PAIN	___ SLEEPING PROBLEMS	___ BACK PAIN
___ NERVOUSNESS	___ TENSION	___ IRRITABILITY	___ CHEST PAINS
___ DIZZINESS	___ FACE FLUSHED	___ NECK STIFF	___ PINS & NEEDLES
___ NUMBNESS	___ BREATHING ISSUES	___ FATIGUE	___ DEPRESSION
___ LIGHT SENSITIVE	___ LOSS OF MEMORY	___ LOSS OF SMELL	___ LOSS OF TASTE
___ DIARRHEA	___ UPSET STOMACH	___ CONSTIPATION	___ HEART BURN
___ RINGING IN EARS	___ LOSS OF BALANCE	___ COLD HANDS/FEET	___ OTHER SYMPTOMS

PRIMARY COMPLAINT

Major complaint: _____ Date it began: _____
Pains are: ___Dull ___Achy ___Sore ___Burning ___Sharp ___Stabbing ___Tight ___Throbbing
Frequency: ___ Constant ___Frequent ___ Intermittent ___ Occasional

Does it Radiate Y N Where? _____ What helps?_____ Aggravates_____

Numbness/Tingling: ____ Muscle Weakness: ____

Pain scale 0 – 10 (10 being worst): 0 1 2 3 4 5 6 7 8 9 10
Time of day condition is worst? Y N If so, when? _____ Home remedies? _____
Is this condition interfering with: Work Sleep Routine Other: _____
Other doctors visited for this problem: _____ Where X-Rays taken? _____

FAMILY HISTORY:

	HEART DISEASE	CANCER	DIABETES	ARTHRITIS	OTHER
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

Anything else the Doctors should know: _____

_____

_____

_____

_____

_____

*PATIENT SIGNATURE _____ DATE _____