

Dr. Jane Torrie, Chiropractor



Name _____ Date _____

Street Address _____

City _____ State _____ Zip _____ Email Address _____

H. Phone _____ Cell Phone _____ Date of Birth _____ Age _____

Referred by _____ Occupation _____ Employer _____

Marital Status S M D W Spouse Name _____

Number of Children/Ages _____ Spouse's Occupation _____

Have you ever received Chiropractic Care? Yes No _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur that can damage your health expression. This case history may help uncover layers of damage, especially to your nervous system and spine, which can result in poor health. Following your assessment, I will outline a course of care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

Loss of Wellness

Please circle for each of the following:

Patient Comment

Chiropractor's Comments

1. Lifetime:

Childhood illnesses?	Y	N	_____	_____
Ear infections/ Colic/ Asthma?	Y	N	_____	_____
Attention Deficit?	Y	N	_____	_____
Accidents?	Y	N	_____	_____
Surgery?	Y	N	_____	_____
Did you fall down stairs?	Y	N	_____	_____
Chair pulled out when sat down?	Y	N	_____	_____
Were you yanked by your arm?	Y	N	_____	_____
Did you have other traumas?	Y	N	_____	_____
Did you ever break any bones?	Y	N	_____	_____

2. Current Health Habits:

Did/do you smoke?	Y	N	_____	_____
Did/do you drink alcohol?	Y	N	_____	_____
Did/do you use caffeine?	Y	N	_____	_____

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Diet, do you eat healthy foods?	Y	N	_____	_____
Have you been in accidents/trauma?	Y	N	_____	_____
Have you had surgery?	Y	N	_____	_____
Teeth problems?	Y	N	_____	_____
Eye problems?	Y	N	_____	_____
Hearing problems?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/Mental stress?	Y	N	_____	_____
Hobbies/Sports injuries?	Y	N	_____	_____
Sleeping posture?	<input type="radio"/> side	<input type="radio"/> stomach	<input type="radio"/> back	_____

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present Complaint/Reason for Seeking Care in this Office:

Pain or Problem started on _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? ___ yes ___ no

Where? _____

Are you experiencing numbness or tingling in any area of your body? ? ___ yes ___ no

Where? _____

What activities aggravate your condition or pain?

What activities lessen your condition or pain?

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

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Please Circle how you feel today:

(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other Doctors seen for this condition _____

Any home remedies? _____

Please mark any of the following that you have now or have experienced:

Other Symptoms:

Headaches

Pain in Hands or Arms

Chest Pains

Neck Pain

Numbness in Hands or Arms

Heart Attack

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- | | | |
|---|---|---|
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |

What other conditions do you have? _____

Have you been under drug and medical care? _____

What Medications are you taking? _____

How long? _____

Have you had surgery? _____ What? _____ When? _____

Have you experienced side effects from the drugs and surgery? _____

Females Only – Date last Menstrual Period began on _____ Are you possibly Pregnant? _____

Male only – Prostate issues _____

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"/> _____

About Your Care

Chiropractic patients often experience several stages of treatment. The first is initial intensive care, which corrects the most recent layer of spinal and neurological damage. This care often reduces or eliminates the symptoms. Then reconstructive care begins, which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to Wellness Care. If you have questions about any of these options please ask. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Signature _____

Patient or Guardian

Date