Welcome to Adkins Chiropractic Life Center

Case History

Patient #_____ Date_____

Last Name _____ First Name_____ M.I._____

Male___ Female___ Age___ Address_____
Street or P.O box City State Zip Code

Home Telephone ( )_____ Work Telephone ( )_____ Date of birth_____

Social Security Number_____ Married____ Single____ Divorced ____ Widowed____

E-mail _____ Employer_____

Occupation_____ Referred by_____

_____

Insurance:

Is your condition due to a work injury? Y N
If yes, will this be a worker's compensation? Y N
If yes, please ask receptionist for a job injury form.
Is your condition due to an auto accident? Y N
If yes, please ask receptionist for a personal injury form.
Are you covered by insurance? Y N
Name of Insurance company_____
Please give your insurance card to receptionist to copy.

Insured's name_____ Birth date of insured_____
Relationship to insured: Self____ Spouse____ Dependent____ Other_____

_____

The human body is designed to be healthy. Most subluxations occur at birth, then throughout life events occur which damage you health expression and cause loss of wellness. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health.

Did your mother have a difficult delivery with you? Y N
Did you have any childhood illnesses? Y N
Did you have any serious falls as a child? Y N
Did you play sports? Y N
Have you had any surgeries? Y N
Have you had any auto accidents? Y N
Prolonged use of medications such as antibiotics? Y N
Do/Did you smoke? Y N
Do/Did you drink alcohol Y N
Have you been hospitalized? Y N
Physical Stress? Y N
Mental Stress? Y N

On a scale of Poor, Good, or Excellent, describe your:
Diet_____ Exercise_____ Sleep_____ General Health_____

Adkins Chiropractic Life Center

Current Symptoms and Ill Health that brought you to this office

What is your complaint that brought you to this office:_____

_____

How long have you had this condition:

_____

Describe pain you are experiencing: Sharp__ Dull__ Ache__ Radiates__ Constant_ Intermittent__
Does it interfere with: Work___ Sleep___ Walking___ Sitting___ Standing___

What activities aggravate your condition?_____

_____

Is your condition getting: Worse___ Better___ Same___
Other doctors who treated you for this condition:_____

_____

Have you had previous chiropractic care? Y N

List medications you are currently taking:

_____

_____

_____

Have You Had:
___Pneumonia
___Polio
___Anemia
___Measles
___Cancer
___Heart Disease
___Thyroid Disease
___Arthritis
___Epilepsy
___High Blood Pressure
___Mental Disorders

Please check any that apply:

___ headaches	___upper back pain	___anxiety
___neck pain	___mid back pain	___neuritis
___neck stiffness	___chest pain	___fatigue
___double vision	___short of breath	___swelling
___numbness/arms	___low back pain	___tension
___dizziness	___numbness/legs	___cold feet
___difficulty in bending	___numbness/feet	___irritability
___difficulty in standing	___fainting	___post eye pain
___pain while walking	___pain while sitting	___tremors
___shoulder pain L or R	___difficulty in lifting	___nausea
___equilibrium problems	___depression	___sweating

_____

Is there a family history of:

	Heart disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	_____	_____	_____	_____	
Mother's side	_____	_____	_____	_____	

Patient's signature_____