Welcome to Superior Chiropractic

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Doctors of Chiropractic & Staff

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip _____

H Phone ( ) _____ W Phone ( )_____ Date of Birth _____ Age _____

Referred By _____ Social Security #_____

Occupation _____ Employer _____

Marital Status S W D M Spouses Name _____ Children Y/ N Ages?_____

Have you ever received chiropractic care before? Yes ☐ No ☐
If yes, please specify care plan:_____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout your 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

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

Yes	No		Comments
		1. Birth Process	
Y	N	Was the delivery long?	
Y	N	Was the delivery difficult?	
Y	N	Caesarean?	
Y	N	Home Birth?	
Y	N	Mother given drugs during delivery?	
Y	N	Delivery Induced?	
Y	N	Instruments Used?	
		2. Growth and Development	
Y	N	Were you breastfed?	
Y	N	Were you taught how to take care of your spine?	
Y	N	Childhood Illnesses or Sickness?	
Y	N	Any Accidents/falls/traumas/automobile injuries?	
Y	N	Drugs/medications?	
Y	N	Surgery?	
		3. Current Health Concerns	
Yes	No		
Y	N	Did/Do you smoke?	
Y	N	Did/Do you drink alcohol?	
Y	N	Do you exercise regularly?	
Y	N	Do you eat healthy?	

How do you sleep?
Stomach/Side/Back

Y N Do you play sports? Hobbies?

Y N Teeth/ Vision/ Hearing troubles?

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

Chief complaint _____

When did it start? _____ Complaint is: Sharp/ Dull/ Constant/ Intermittent

Which activity aggravates your condition? _____

Which activity lessons your condition? _____ Better or Worse / AM or PM

What is this condition interfering with? Activities/ Work/ Sleep/ Family/ Children/ Other: _____

Is the condition getting worse? _____

What have you done prior to your care here? _____ Any home remedies? _____

Notes:

Other Symptoms

☐ Headaches	☐ Shortness of breath	☐ Tingling in Arms	☐ Fainting
☐ Neck Pain	☐ Sleeping problems	☐ Nervousness	☐ Tension/Irritability
☐ Back Pain	☐ Fatigue	☐ Diarrhea	☐ Not feeling like yourself
☐ Chest Pain	☐ Dizziness	☐ Stomach Pains	☐ Loss of Balance
☐ Ringing Ears	☐ Ear Ache/Infections	☐ Constipation	☐ Depression
☐ Tingling Feet	☐ Carpal Tunnel	☐ Cold Hands/ Feet	☐ Diabetes
☐ Allergies	☐ Asthma	☐ Acid Reflux	☐ High Blood Pressure
☐ Fibromyalgia	☐ Colic	☐ _____ Other	

Have you been under drug or Medical care? _____

What Medication(s) are you taking and for what conditions? _____

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

_____

Are you submitting your bills to an insurance company for reimbursement?_____ What company?_____

Who is responsible for paying for your care? _____

Method of payment? CASH/ CHECK/ or CREDIT CARD

Credit card # _____ Exp. Date:_____

Name as it appears on the card: _____

Affix signature here: _____

Print Name here: _____

CHIROPRACTIC CARE AT THIS OFFICE PROVIDES THREE TYPES OF CARE:

- **THE FIRST PHASE OF CARE IS THE INITIAL INTENSIVE CARE PHASE**
- **THE SECOND PHASE OF CARE IS THE CORRECTIVE OR SPINAL HEALING PHASE**
- **THE THIRD AND MOST IMPORTANT PHASE OF CARE IS HEALTH OPTIMIZATION/WELLNESS**

ALL OF THESE OPTIONS WILL BE EXPLAINED AT YOUR REPORT OF FINDINGS. YOU WILL THEN BE ABLE TO BEGIN A COURSE OF CARE THAT BEST FITS YOUR HEALTH GOALS.

Thank you for choosing Superior Chiropractic