SUPERIOR
FAMILY CHIROPRACTIC

www.superiorfamilychiropractic.com | 45070 US-41, Chassell, MI 49916 | 906-482-2400

Last Name _____ **First Name** _____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

H Phone ( ) _____ **W/C Phone ( )**_____ **Date of Birth** _____ **Age** _____

Email Address_____ **Would you like to receive our Newsletter by email? □Yes □No**

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 can 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.

Let's begin at birth. Birth can often be the cause of your first subluxation or when you first damaged your nerve system that could have led to a loss of wellness.

Yes	No		Comments
		1. **Birth Process and Childhood**	
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?	
Y	N	Were you breastfed?	
		2. **Childhood and Beyond**	
Y	N	Major illnesses or sickness? If yes, what?	
Y	N	Any accidents/falls/traumas/automobile injuries? If yes, please list on next page.	
Y	N	Drugs/medications? Please list what medications and for what conditions. *Ask the front desk staff to copy your medication list if you have one.*	
Y	N	Surgery? Please list on next page.	
Y	N	Do you get common colds/illnesses often?	
Y	N	Do you feel you have good immunity overall?	
Y	N	Do you have a family history of any chronic illnesses or diseases? If yes, please list on next page.	

Additional space on back if needed

3. **Current Health**

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?
Y N Do you get quality sleep?
How do you sleep?
Stomach/Side/Back
Y N Do you play sports? Hobbies?
Y N Teeth/ Vision/ Hearing troubles?
Y N Have you been under drug or medical care for any conditions? If yes, please list below.

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	

Acute or chronic symptoms can often be traced back to damage from previous spinal macro and micro traumas. Tell us more about what you are experiencing:

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:

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

Who is responsible for paying for your care? _____

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.