Today's Date _____

Name _____

Date of Birth _____ **Age** _____

Address _____

City, State, Zip Code _____

H Phone ( ) _____ **W/C Phone ( )**_____

Email Address_____ **Would you like to receive our Newsletter by email? Y/N**

Referred By _____ **Social Security #**_____

Occupation _____ **Employer** _____

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

SUPERIOR FAMILY CHIROPRACTIC

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Dr. Mischa N. Doman, DC
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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.

1. YOUR 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?
Y N Were you breastfed?

2. CHILDHOOD & BEYOND

Y N Major illnesses or sickness? If yes, what?

_____

Y N Any history of torticollis/plagiocephaly/helmet usage?

_____

_____

Y N Diagnosed with scoliosis?

_____

Y N Any accidents, falls, traumas, automobile injuries?
If yes, please list:

_____

_____

_____

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:

_____

_____

_____

_____

_____

_____

_____

_____

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 or have hobbies?

_____

Y N Teeth/ Vision/ Hearing troubles?
Y N Have you been under drug or medical care for any conditions?
If yes, please list:

_____

_____

Y N Have you been under chiropractic care before?
If yes, please describe care plan:_____

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 Aches/Infection
- Constipation
- Depression
- Tingling Feet
- Carpal Tunnel
- Cold Hands/ Feet
- Diabetes
- Allergies
- High Blood Pressure
- Fibromyalgia
- Asthma
- Acid Reflux
- 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 Is it: Better/Worse in the Morning/Evening?

Which activity aggravates your condition? _____

Which activity lessons your condition? _____

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

_____

Is the condition getting worse? _____

Any medical or home care prior to your care here? OTC Meds/Home Remedies/Other Providers

_____

INSURANCE INFORMATION:

Are you submitting your bills to an insurance company for reimbursement? Y N

What company?_____

NOTES:

SUPERIOR
FAMILY CHIROPRACTIC

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.