Application for Treatment and Your Case History

Birth Name_____ Nick Name: _____
Address_____ City _____ State_____ Zip_____
Cell Phone (____)_____ H/W Phone (____)_____
Social Security #_____ Date of Birth: ____/____/_____ Age: _____
Occupation_____ Employer_____
Marital Status S M D W Number of Children/Ages:_____/_____
Spouses Full Name:_____ Spouses Occupation_____
Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, Date of last visit?_____
Referred by: _____

In event of emergency Who should we contact?_____
Phone ( ) _____ Relation to you? _____
Name of Primary Care Physician? _____ Phone: _____
Date of Physical?_____ Date of Last Primary Care Visit?_____

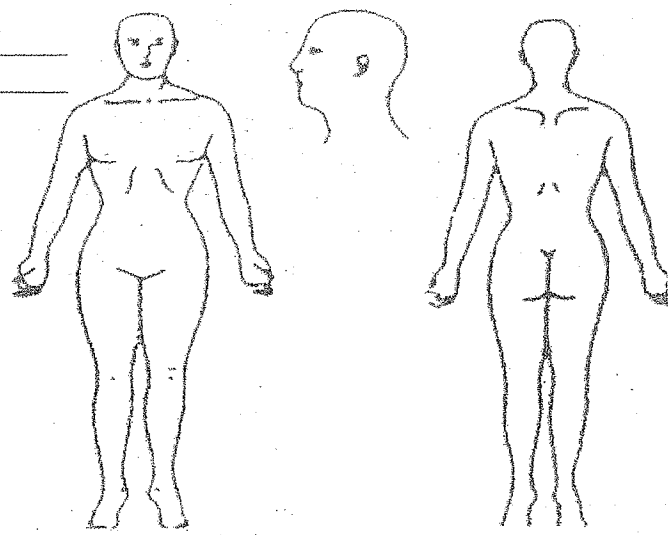
About Your Health

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

Loss of Wellness: Using the adjacent body charts, please mark all affected areas.

Present Complaint/Reason for Seeking Care in this Office:

1. _____
2. _____



☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness
Pain ☐ Sharp ☐ Dull/ Ache ☐Constant ☐Intermittent ☐Other
Rate your pain, discomfort with the following 1-10 scale:

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

☐ getting worse ☐ staying the same ☐ constant ☐ comes and goes
Is your condition interfering with your: ☐work ☐sleep ☐daily
Has this or something similar happened in the past? ☐Yes ☐No
Have you been treated by another doctor? ☐Yes ☐No

Let's begin to look at the journey to your present health. **Please circle for each of the following:**

Childhood illnesses?	Y	N	Have you been in accidents/trauma?	Y	N
Ear infections/ Colic/ Asthma?	Y	N	Have you had surgery	Y	N
Attention Deficit?	Y	N	Any body parts removed/replaced?	Y	N
Accidents?	Y	N	Drugs, including Prescription?	Y	N
Taking ANY medications/drugs?	Y	N	Teeth problems?	Y	N
Any Scars	Y	N	Eye problems?	Y	N
Did you fall down stairs?	Y	N	Hearing problems?	Y	N
Chair pulled out when sat down?	Y	N	Exercise regularly?	Y	N
Were you yanked by your arm?	Y	N	Did/do you have occupational stress?	Y	N
Did you have other traumas?	Y	N	Physical stress?	Y	N
Did you ever break any bones?	Y	N	Emotional/Mental stress?	Y	N
Did/do you smoke?	Y	N	Hobbies/Sports injuries?	Y	N
Did/do you drink alcohol?	Y	N	Do You Sleep Well?	Y	N
Diet, do you eat healthy foods?	Y	N			

Indicate Symptoms / Conditions you have or you may have had in the past:

O Headaches	O Pain in Hands or Arms	O Chest Pains	O Implants
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack	O Glaucoma
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure	O HIV/AIDS
O Low Back Pain	O Numbness in Legs or Feet	O Stroke	
O Nervousness	O Fatigue	O Cancer	O PTSD
O Tension	O Depression	O Painful Urination	
O Irritability	O Lights Bother Eyes	O Diabetes	O Ringing in Ears
O Dizziness	O Loss of Memory	O Diarrhea	
O Pain Between Shoulders	O Shoulder Pain	O Constipation	O Need Glasses/Contacts
O Neck Stiff	O Sinus	O Stomach Upset	
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps	
O Fever	O Asthma	O Weight Loss /Weight Gain	
O Loss of Balance	O Allergies	O Loss of Smell or Taste	

Have you been under drug and medical care?_____
What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage **(VSC Vertebral Subluxation Complex)**. This care often reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained giving you the tools 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 Simply Chiropractic and Acupuncture to do whatever is necessary in accordance with this state's statues, to provide me with medical care.

I understand that payment is due upon arrival. I have signed the consent to treatment.

24 hour notice is required to change or cancel any schedule appointment.
$30 fee will apply for any late cancellations, late changes to appointment or a NO show.

Print Name: _____ Date of Birth: _____

Patient or Guardian Signature_____Date_____

PRINT Email we may use to contact you _____

Best Phone number to reach you, leave messages or call: _____

Best phone Number we may TEXT appointment reminders: _____