NEW ENGLAND SPINAL CARE

Case History

Name ______________________ Called Name ______________________ Date ____________

Address ______________________ City ____________ State ______ Zip ____________

Date of Birth ____________ (Age) Social Security # ____________

H. Phone ( ) W. Phone ( ) Cell Phone ( )

Where do you prefer to be contacted: [ ] Home [ ] Work [ ] Cell

Occupation ______________________ Employer ______________________

Marital Status S M D W Spouses Name ____________ Date of Birth ____________

Spouses Occupation ______________________ Number of Children and Ages ____________

Referred by ______________________

Have you ever received Chiropractic Care? [ ] Yes [ ] No

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, 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 you journey to ill health.

Yes	No		Patient Comment if answer is Yes	Chiropractor's Comments
		1. Birth Process		
[ ]	[ ]	Was the delivery long?		
[ ]	[ ]	Was the delivery difficult?		
[ ]	[ ]	Forceps?		
[ ]	[ ]	Caesarean?		
[ ]	[ ]	Breach/Cephalic?		
[ ]	[ ]	Home birth?		
[ ]	[ ]	Hospital birth?		
[ ]	[ ]	Mother given drugs during delivery?		
[ ]	[ ]	Was labor induced?		
		2. Growth & Development		
[ ]	[ ]	Were you taught how to care for your spine?		
[ ]	[ ]	Did you fall out of bed?		
[ ]	[ ]	Were you a headbanger or rocker?		
[ ]	[ ]	Were you breast fed?		
[ ]	[ ]	Childhood sicknesses?		
[ ]	[ ]	Accidents in childhood?		
[ ]	[ ]	Surgery?		
[ ]	[ ]	Drugs?		
[ ]	[ ]	Did you fall while learning to walk?		
[ ]	[ ]	Were you picked on by siblings?		
[ ]	[ ]	Child abuse?		
[ ]	[ ]	Spanking (how?)		
[ ]	[ ]	Pulled ear/chin		
[ ]	[ ]	Other		
[ ]	[ ]	Chair pulled out when you sat down?		
[ ]	[ ]	Did you fall down stairs?		
[ ]	[ ]	Were you yanked by your arm?		
[ ]	[ ]	Did you have other traumas? What? When?		

Yes	No	3. Current Health Habits		
[ ]	[ ]	Did/do you smoke?		
[ ]	[ ]	Did/do you drink any alcohol?		
[ ]	[ ]	Diet (Do you eat healthy foods?)		
[ ]	[ ]	Have you been in accidents?		
[ ]	[ ]	Have you been in accidents as an adult?		
[ ]	[ ]	Have you had surgery and organs removed/replaced?		
[ ]	[ ]	Drugs? (presciption or non-prescription)		
[ ]	[ ]	Teeth problems?		
[ ]	[ ]	Eye problems?		
[ ]	[ ]	Hearing problems?		
[ ]	[ ]	Exercise regularly? (please specify type & amt)		
[ ]	[ ]	Sleeping habits (nightmares?)		
[ ]	[ ]	Did/do you have occupational stress?		
[ ]	[ ]	Physical stress?		
[ ]	[ ]	Mental stress?		
[ ]	[ ]	Hobbies/Sports injuries?		
[ ]	[ ]	Sleeping posture [ ] side [ ] stomach [ ] back		

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms:

Present Complaint (be brief)

Major ______

Pain or Problem started on ______

Pains are: [ ] Sharp [ ] Dull [ ] Constant [ ] Intermittent

What activities aggravate your condition/pain? ______

What activities lessen your condition/pain? ______

Is condition worse during certain times of the day? ______

Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? ______

Is condition getting progressively worse? ______

Other Doctors seen for this condition ______

Any home remedies? ______

Other symptoms:

[ ] Headaches/ Migraines	[ ] TMJ	[ ] Frequent Colds/flus	[ ] Pins & Needles in legs
[ ] Neck Pain/Stiffness	[ ] Nervousness	[ ] Loss of Smell/ Taste	[ ] Pins & Needles in Arms
[ ] Upper/mid back pain	[ ] Sleeping difficulty	[ ] Asthma/brochitis	[ ] Numbness in Fingers
[ ] Low back pain	[ ] Loss of energy	[ ] Shortness of breath	[ ] Numbness in Toes
[ ] Shoulder pain (L / R / Both)	[ ] Loss of Concentration	[ ] Chest Pains	[ ] Feet Cold
[ ] Arm/Elbow pain (L / R / Both)	[ ] Run Down/ Fainting	[ ] Blurred Vision	[ ] Hands Cold
[ ] Hand/Wrist pain (L / R / Both)	[ ] Sinus pain/allergies	[ ] Depression	[ ] Cold Sweats
[ ] Hip Pain (L / R / Both)	[ ] Dizziness	[ ] Digestive trouble	[ ] Fatigue
[ ] Leg/Knee pain (L / R / Both)	[ ] Ears Ring/ Buzz	[ ] Constipation/ Diarrhea	[ ] Emotional Stress
[ ] Ankle/Foot pain (L / R / Both)	[ ] Loss of Balance	[ ] Reflux	[ ] Light Bothers Eyes

Have you been under drug and medical care? ______

What medications are you taking? ______

How Long? ______ Have you had surgery? ______

what side effects have you experienced from the drugs and surgery? ______

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other ______
Father's Side	[ ]	[ ]	[ ]	[ ]	[ ]
Mother's Side	[ ]	[ ]	[ ]	[ ]	[ ]

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were a few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings.

Then you'll be able to begin a the care that fits your health goals.

New England Spinal Care

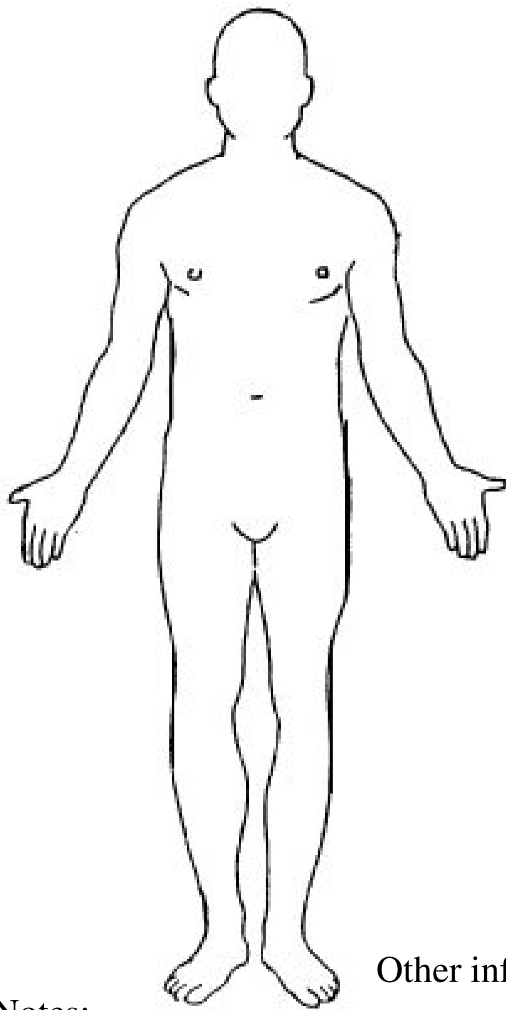
Pain Diagram

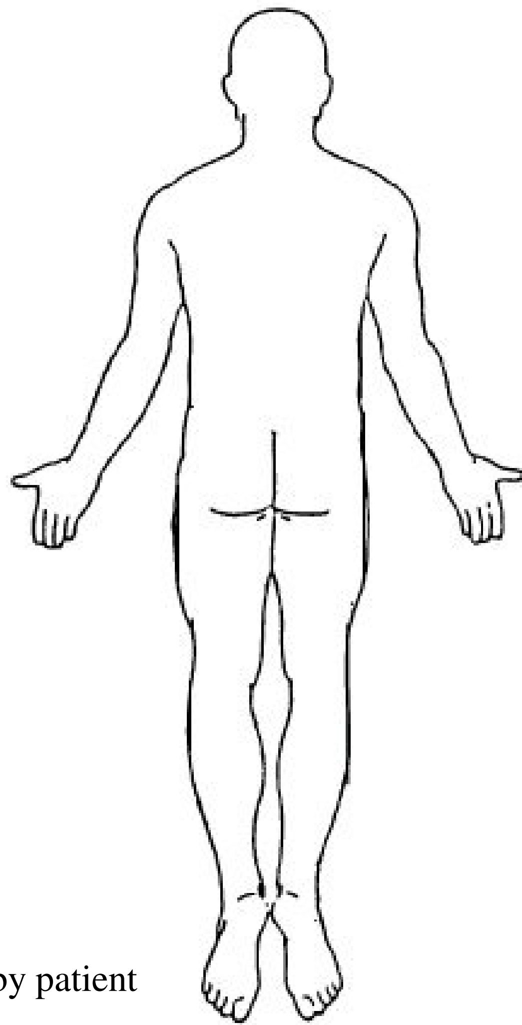
NAME: ____DATE: ______________

Mark the areas on your body where you feel symptoms. Use the appropriate symbol(s) lieted below. Include all affected areas.

Dull pain:	dp	Burning:	bu	Sharp Pain:	sp
Stabbing:	st	Aching:	ac	Tingling:	ti
Throbbing:	th	Numb:	nu	Sore:	so
		Stiff:	stf		

SEVERITY SCALE:
Please indicate severity with 0 being no problem to 10 being severe.





Other info/notes by patient

Notes:

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