

Welcome to Adkins Chiropractic Life Center
Case History

Patient # _____ Date _____

Last Name _____ First Name _____ M.I. _____

Male ___ Female ___ Age ___ Address _____
Street or P.O box City State Zip Code

Home Telephone () _____ Work Telephone () _____ Date of birth _____

Social Security Number _____ Married ___ Single ___ Divorced ___ Widowed ___

E-mail _____ Employer _____

Occupation _____ Referred by _____

Insurance:

Is your condition due to a work injury? Y N

If yes, will this be a worker's compensation? Y N

If yes, please ask receptionist for a job injury form.

Is your condition due to an auto accident? Y N

If yes, please ask receptionist for a personal injury form.

Are you covered by insurance? Y N

Name of Insurance company _____

Please give your insurance card to receptionist to copy.

Insured's name _____ Birth date of insured _____

Relationship to insured: Self ___ Spouse ___ Dependent ___ Other _____

The human body is designed to be healthy. Most subluxations occur at birth, then throughout life events occur which damage you health expression and cause loss of wellness. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health.

Did your mother have a difficult delivery with you? Y N

Did you have any childhood illnesses? Y N

Did you have any serious falls as a child? Y N

Did you play sports? Y N

Have you had any surgeries? Y N

Have you had any auto accidents? Y N

Prolonged use of medications such as antibiotics? Y N

Do/Did you smoke? Y N

Do/Did you drink alcohol Y N

Have you been hospitalized? Y N

Physical Stress? Y N

Mental Stress? Y N

On a scale of Poor, Good, or Excellent, describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Adkins Chiropractic Life Center
Current Symptoms and Ill Health that brought you to this office

What is your complaint that brought you to this office: _____

How long have you had this condition: _____

Describe pain you are experiencing: Sharp__ Dull__ Ache__ Radiates__ Constant_ Intermittent__
Does it interfere with: Work__ Sleep__ Walking__ Sitting__ Standing__

What activities aggravate your condition? _____

Is your condition getting: Worse__ Better__ Same__
Other doctors who treated you for this condition: _____

Have you had previous chiropractic care? Y N

List medications you are currently taking: _____

Have You Had:

- ___ Pneumonia
- ___ Polio
- ___ Anemia
- ___ Measles
- ___ Cancer
- ___ Heart Disease
- ___ Thyroid Disease
- ___ Arthritis
- ___ Epilepsy
- ___ High Blood Pressure
- ___ Mental Disorders

Please check any that apply:

- | | | |
|----------------------------|---------------------------|-------------------|
| ___ headaches | ___ upper back pain | ___ anxiety |
| ___ neck pain | ___ mid back pain | ___ neuritis |
| ___ neck stiffness | ___ chest pain | ___ fatigue |
| ___ double vision | ___ short of breath | ___ swelling |
| ___ numbness/arms | ___ low back pain | ___ tension |
| ___ dizziness | ___ numbness/legs | ___ cold feet |
| ___ difficulty in bending | ___ numbness/feet | ___ irritability |
| ___ difficulty in standing | ___ fainting | ___ post eye pain |
| ___ pain while walking | ___ pain while sitting | ___ tremors |
| ___ shoulder pain L or R | ___ difficulty in lifting | ___ nausea |
| ___ equilibrium problems | ___ depression | ___ sweating |

Is there a family history of:

	Heart disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	_____	_____	_____	_____	
Mother's side	_____	_____	_____	_____	

Patient's signature _____