Case History

Name_____Date_____
Address_____ State_____
H. Phone (_____)_____ W. Phone_____ Date of Birth_____
Age_____ Referred by:_____ Social Security#_____
Occupation_____Employer_____
Marital Status: S M D W Spouses Name_____ Spouses Occupation_____
Number of children/Ages_____ Have you ever received Chiropractic Care?_____

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 nervous system and spine, which can result in poor health. Following your exam, Dr. Cappiello will outline a course of care, which will begin to connect these layers of damage and to help you recover your inborn/innate health potential.

Loss of Wellness

Let's begin at birth, when you may have first damaged your nervous system/spine, lost wellness, and began your journey to your present health.

Please circle Y or N for each of the following:			Patient Comment If Answer is Yes	Chiropractor's Comments
1. Regarding your birth process:				
Was the delivery long/difficult?	Y	N	_____	_____
Forceps or extraction used?	Y	N	_____	_____
Cesarean/ C –Section?	Y	N	_____	_____
Breach/ Cephalic?	Y	N	_____	_____
Home Birth?	Y	N	_____	_____
Hospital Birth?	Y	N	_____	_____
Mother given drugs during delivery?	Y	N	_____	_____
Was labor induced?	Y	N	_____	_____
2. Regarding your Growth and Development? Childhood:				
Were you breast fed?	Y	N	_____	_____
Were you taught how to care for your spine?	Y	N	_____	_____
Childhood Illnesses?	Y	N	_____	_____
Ear infections/ Colic/ Asthma?	Y	N	_____	_____
Attention Deficit?	Y	N	_____	_____
Accidents?	Y	N	_____	_____
Drugs, including prescription?	Y	N	_____	_____
Surgery?	Y	N	_____	_____
Did you fall down the stairs?	Y	N	_____	_____
Chair pulled out from you when you sat down?	Y	N	_____	_____
Were you ever yanked by your arm?	Y	N	_____	_____
Did you have other traumas?	Y	N	_____	_____
Did you ever break any bones?	Y	N	_____	_____
3. Current Health Habits:				
Did/ Do you smoke?	Y	N	_____	_____
Did/ Do you drink alcohol?	Y	N	_____	_____
Diet, do you eat healthy foods?	Y	N	_____	_____
Have you been in any accidents/ trauma?	Y	N	_____	_____
Have you had surgery and any organs removed/ replaced?	Y	N	_____	_____
Drugs, including prescription?	Y	N	_____	_____
Teeth problems?	Y	N	_____	_____
Eye problems?	Y	N	_____	_____

Hearing problems?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/ Do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/ Mental stress?	Y	N	_____	_____
Hobbies/ Sports injuries?	Y	N	_____	_____
Sleeping posture? Side Stomach Back			_____	_____

Symptoms and Present State of Health:

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present complaint/ reason for seeking care in this office? _____

Pain or Problem started on: _____

Pains are: Sharp Dull with ache Constant Intermittent Other

Does this pain radiate, or travel in your body? Where? _____

Are you experiencing numbness or tingling in any area of your body? Where? _____

What activities aggravate your condition/ pain? _____

What activities lessen your condition/ pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routines? _____

Is this condition progressively getting worse? _____

Please circle where your pain level is: 0 being no complaint/ no pain, 10 being worst possible complaint/pain

0 1 2 3 4 5 6 7 8 9 10

Have you seen other Doctors for this condition? _____

Any home remedies? _____

Please mark any of the following that you now or have experienced?

_____ Headaches	_____ Pain in Hands or Arms	_____Chest Pains
_____ Neck Pains	_____ Numbness in hands or arms	_____ Heart Attack
_____ Sleeping Problems	_____ Pain in legs or feet	_____ High Blood Pressure
_____ Low back pain	_____ Numbness in legs or feet	_____ Stroke
_____ Nervousness	_____ Fatigue	_____ Cancer
_____ Tension	_____ Depression	_____ Painful Urination
_____ Irritability	_____ Lights bother eyes	_____ Diabetes
_____ Dizziness	_____ Loss of memory	_____ Constipation
_____ Pain between shoulders	_____ Shoulder Pain	_____ Stomach upset
_____ Neck Stiff	_____ Sinus	_____ Diarrhea
_____ Joint swelling	_____ Shortness of breath	_____ Menstrual Changes
_____ Fever	_____ Asthma	_____ Weight Loss
_____ Loss of balance	_____ Allergies	_____ Loss of smell or taste

Have you been under drug and medical care?_____

What medications are you taking?_____

How long?_____ Have you had surgery?_____ When?_____

What side effects have you experienced from the drugs and from 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	_____	_____	_____	_____	_____
Mother's side	_____	_____	_____	_____	_____

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. 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. 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 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 Chiropractic to do whatever is necessary in accordance with this state's guidelines, to provide me with chiropractic care.

Patient Signature_____Date_____