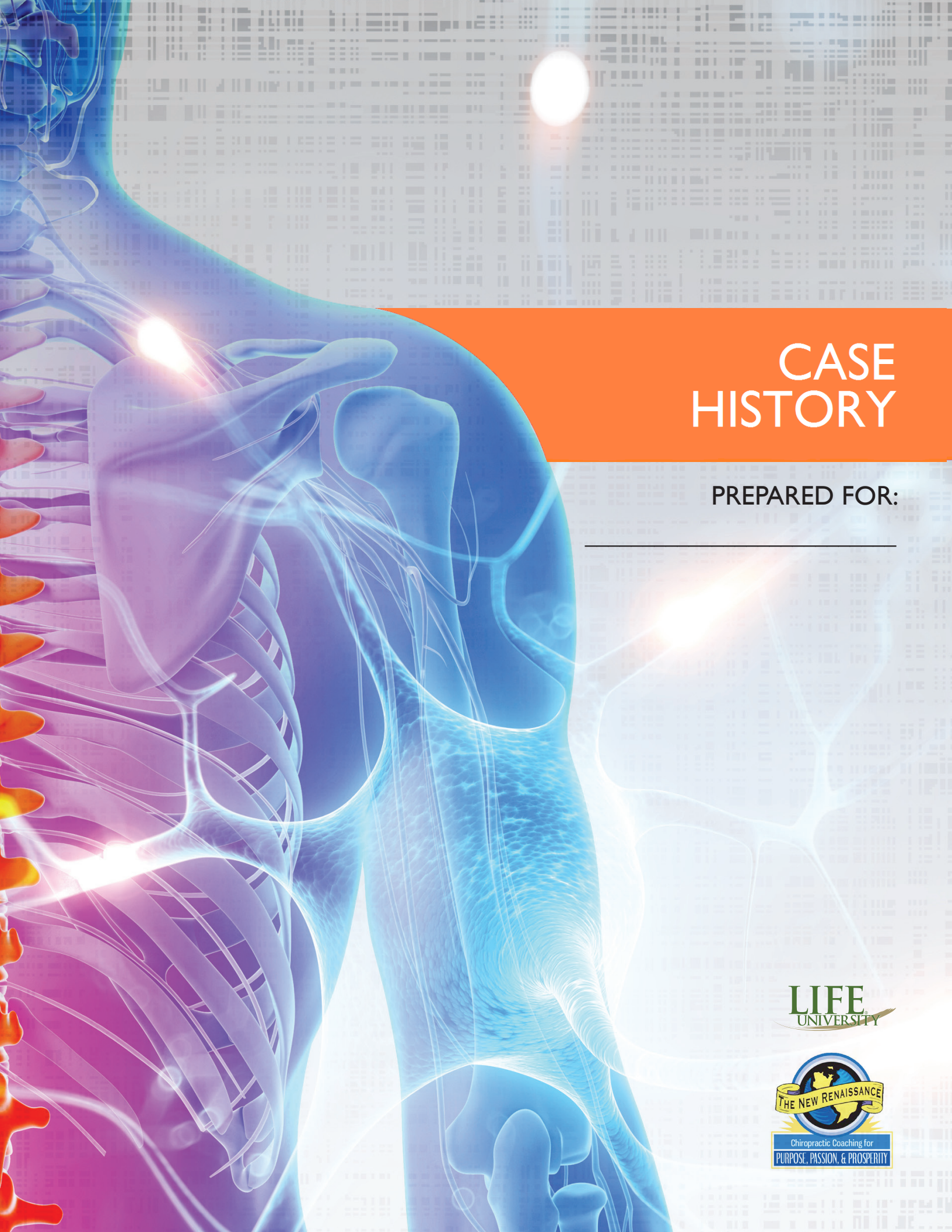

CASE HISTORY

PREPARED FOR:

_____

LIFE UNIVERSITY

THE NEW RENAISSANCE

Chiropractic Coaching for

PURPOSE, PASSION, & PROSPERITY

Name: _____ Date: _____

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 have 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.

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Conditioned Based Care, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins Corrective 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 at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

LOSS OF WELLNESS (BIRTH - AGE 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes	No	1. Pregnancy	Patient Comment (if answer is yes)	Chiropractor's Comments
		Did your mother:		
☐	☐	Have a proper diet?	_____	_____
☐	☐	Exercise?	_____	_____
☐	☐	Smoke or drink alcohol?	_____	_____
☐	☐	Take any medication/vaccines	_____	_____
☐	☐	Experience any falls/injuries during pregnancy?	_____	_____
☐	☐	Experience any physical/mental abuse?	_____	_____
☐	☐	Get ultrasounds done? How many?	_____	_____
☐	☐	Have abnormal findings (blood, ultrasound, other)?	_____	_____
☐	☐	Have problems during pregnancy?	_____	_____
		2. Birth Process		
☐	☐	Was the delivery long/difficult?	_____	_____
☐	☐	Breech/cephalic presentation?	_____	_____
☐	☐	Forceps? Vacuum? (specify)	_____	_____
☐	☐	Caesarean section? (planned or emergency)	_____	_____
☐	☐	Hospital Birth?	_____	_____
☐	☐	Was labour induced?	_____	_____
☐	☐	Mother given drugs during delivery?	_____	_____
☐	☐	Problems during labour/delivery?	_____	_____
☐	☐	Congenital abnormalities	_____	_____
☐	☐	Injuries at birth? (e.g. torticollis)	_____	_____
		3. Growth and Development		
☐	☐	Were you breastfed? How long?	_____	_____
☐	☐	Developmental milestones reached on time?	_____	_____
☐	☐	Did you fall from crib, bed, change table etc.?	_____	_____
☐	☐	Childhood diseases? (ear infections, measles etc.)	_____	_____
☐	☐	Were you vaccinated (fully/partial)?	_____	_____
☐	☐	Were you picked on by siblings?	_____	_____
☐	☐	Mental/physical/sexual abuse?	_____	_____
☐	☐	Spanking (How?)	_____	_____
☐	☐	Were you yanked by your arm?	_____	_____
☐	☐	Did you fall off skateboard/skates/bicycle?	_____	_____
☐	☐	Did you fall from playground apparatus?	_____	_____
☐	☐	Any other traumas? What? When?	_____	_____
☐	☐	Did you have surgery/hospital visits?	_____	_____

Name: _____ Date: _____

LOSS OF WHOLE BODY HEALTH (AGE 5 – PRESENT)

As layers of damage increase, you will probably experience symptoms and random bouts of sickness.

Yes	No		Patient Comment (if answer is yes)	Chiropractor's Comments
☐	☐	Have you ever been in accidents?	_____	_____
☐	☐	Have you had surgery and organs removed/replaced?	_____	_____
☐	☐	Drugs prescriptive/non-prescriptive? (vaccines?)	_____	_____
☐	☐	Reactions to vaccines or drugs?	_____	_____
☐	☐	Hobbies/Sports injuries?	_____	_____
☐	☐	Mental stress?	_____	_____
☐	☐	Have you been teased or bullied?	_____	_____
☐	☐	Sleeping habits (nightmares/insomnia, etc.)	_____	_____
☐	☐	Eye problems?	_____	_____
☐	☐	Hearing problems?	_____	_____
☐	☐	Teeth problems?	_____	_____
☐	☐	Exercise regularly?	_____	_____
☐	☐	Were you taught proper body movement and care?	_____	_____
☐	☐	Diet (do you eat healthy food)?	_____	_____
☐	☐	Food allergies/intolerances?	_____	_____
☐	☐	Any major life changes (separation, move, change jobs, death in family)?	_____	_____

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of untreated damage shows up as acute or chronic symptoms. Check of any of the symptoms you have experienced:

☐ Headaches	☐ Shoulder pain	☐ Lights bothers eyes	☐ Difficulty sleeping
☐ Neck pain/stiffness	☐ Elbow pain	☐ Loss of smell/taste	☐ Allergies
☐ Upper back pain/stiffness	☐ Wrist/hand pain	☐ Grinding teeth	☐ Frequent/prolonged colds
☐ Chest pain	☐ Numb/tingling arms/hands	☐ Ringing/buzzing in ears	☐ Digestive problems
☐ Lower back pain	☐ Numb/tingling legs/feet	☐ Hearing loss	☐ Weight trouble
☐ Hip pain	☐ Cold hands/feet	☐ Fatigue	☐ Skin issues
☐ Knee pain	☐ Dizziness/vertigo	☐ Irritability/Hypersensitivity	☐ Mental fog/Memory loss
☐ Ankle/foot pain	☐ Loss of balance	☐ Depression/	☐ Hormonal Issues
☐ Poor coordination	☐ Shortness of breath	☐ Nervousness	☐ _____

Major complaint: _____

When did pain or problem start? _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent Is condition getting progressively worse? ☐ Yes ☐ No

What activities aggravate your condition/pain? _____

_____

Is condition worse during certain times of the day? ☐ Yes ☐ No If so, when? _____

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other: _____

_____ _____ _____

Other doctors seen for this condition? _____

Any home remedies? _____

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Are you under medical care for other conditions? ☐ Yes ☐ No

If yes, please explain: _____

What medications are you taking? _____ How long? _____

Have you had surgery? ☐ Yes ☐ No For what? _____

When? _____

What side effects (if any) did you experience from drugs and surgery? _____

_____

FAMILY HISTORY

Father's side:

- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Mother's side

- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

PATIENT INFORMATION

Name: _____ Care card # _____ Date: _____

Gender: ☐ Male ☐ Female Date of Birth _____ (Age: ____)

Address: _____ City: _____Province:_____ Postal Code: _____

Cell phone # _____ Home phone # _____ Work phone # _____

Email: _____

Occupation: _____ Employer: _____

Marital status: S M D W Spouse's name and occupation: _____

Number of children and ages: _____

Have you ever received chiropractic care? ☐ Yes ☐ No Name of your family doctor: _____

Have you ever been in an accident? ☐ Yes ☐ No ☐ Auto ☐ Work

Nature of accident: _____ When: _____

Did you require hospitalization? ☐ Yes ☐ No Did you lose days of work as a result? ☐ Yes ☐ No How many? _____

Is insurance involved? ☐ Yes ☐ No Which company? _____

Attorney's name: _____ Claim number: _____

If you were referred, by whom? _____