CASE HISTORY

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Hm Phone_____ Cell Phone_____ Wk Phone_____
Email_____
Date of Birth_____/_____/_____ Age _____ Social Security _____
Employer _____ Occupation _____
Referred By _____ Marital Status S M D W
Spouses Name_____ Occupation _____ Employer _____
Number of Children & Ages _____

What are your health concerns and when did each start:
A:_____D._____
_____
B._____E._____
_____
C._____F._____
_____

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 condition interfering with work?_____ Sleep?_____ Routine?_____ Other? _____
Is condition getting progressively worse? _____
Other Doctors seen for this condition_____
Any home remedies?_____

What do you think is causing your concerns?_____
Why do you think that?_____
When it's at its absolute worst, what's it like?_____
What is it like @ work? _____
Does it concern you that it affects work?_____
What is it like @ home? _____
Does it concern you that it's getting worse?_____
What do you like to do when you feel good?_____
The better we understand your goals, the better we'll be able to help meet those.
What are your goals at our office? _____

Are you interested in more of a temporary fix (person has to come again and again for the same problem), or a permanent solution if you could achieve that (correct the underlying problem)?_____
How long are you expecting it will take to achieve a permanent solution? _____

Our goals are to specifically identify the cause of your problems and to determine if you have any underlying health issues in addition to your main concerns. We achieve outstanding results in our office, however, in the event we are unable to help you, we'll make sure you are referred to the appropriate place. Does that sound fair? Yes No

The next series of questions will help us better understand how you got to the place you are today. In fact, **most people we see like you have had some physical trauma that has laid the foundation for problems down the road.** Even the most **minor** physical events can cause undetected damage to ligaments, muscles, joints and nerve tissue. We don't know if this is the case for you but let's find out.

1st MVA/fender bender _____speed_____ Other MVA'S_____
Sports/injuries_____Slips_____falls_____
Work injuries_____ childhood injuries_____ abuse_____
Poor posture_____ repetitive lifting_____ prolonged time standing/sitting_____

Emotional stress can lay the foundation for problems just like the ones you could be experiencing, it's very common. Any negative experience leaves an imprint on the nerve system, causing health problems. In fact research shows **70%** of patients with symptoms and health problems are from emotional stress. This may or may not be the case for you, but let's find out. Have you experienced any of the following **in your lifetime or the past 20-30 years**?

Losses/trauma's_____ emotional abuse/neglect_____
financial stress_____ anger/sadness _____ depression _____
work stress_____ family stress_____ relationships_____

We are exposed to over 200 chemicals on a daily basis! Chemical stresses can damage your nerve system, resulting in negative health consequences. It's impossible to identify every one, so let's identify the common ones. **Please identify what kind, how much/day and number of years using.**

Organic food_____ sugar_____ sodas/diet_____ alcohol_____
artificial sweeteners _____ tobacco_____ caffeine_____ junk food _____
fast food_____ processed/boxed foods_____ microwave food_____
work/cleaning chemicals_____ fruit and veggies_____ daily water intake_____oz.

If your health concerns or pain went away, would you consider yourself healthy? (1-10)_____

At Polson Family Chiropractic, we identify and correcting the underlying cause of your health concerns, develop a plan to correct the problem, and restore optimum health and wellbeing.

Have you ever seen a Wellness Chiropractor before? Yes No
What has your experience with Chiropractic care been?_____

Other symptoms:

□ Anxiety	□ Headaches	□ Loss of Taste/ Smell	□ Shortness of Breath
□ Depression	□ Neck Pain/Stiff	□ Fainting	□ Buzzing/ Ringing in Ears
□ Fatigue	□ Back Pain	□ Face Flushed	□ Feet/Hands Cold
□ Dizziness	□ Numbness in Toes	□ Diarrhea	□ Loss of Memory
□ Nervousness	□ Numbness in Fingers	□ Constipation	□ Cold Sweats
□ Irritability	□ Pins & Needles in Arms	□ Stomach Upset	□ Fever
□ Tension	□ Pins & Needles in Legs	□ Chest Pains	□ Loss of Balance
□ High Blood Pres.	□ Sleeping Problems	□ Lights Bother Eyes	□ Heart Palpitation

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?_____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	□	□	□	□	□
Mother's side	□	□	□	□	□

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge, I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

Signature _____ Date _____