

Adult Case History

PLEASE PRINT

Full Name: _____ Male Female Date: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Name of Spouse/Significant other if applicable: _____ Spouse's Birthdate & Occupation _____

Number of Children & Ages: _____

Home Mailing Address: _____ City _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell or Mobile Phone #: _____

E-mail Address: _____

Employer: _____ Emergency Name and Number: _____

How did you hear about Cornish Family Chiropractic? Who can we thank for referring you _____
Is there a specific reason for consulting our office at this time? There is more room on the next page for additional writing.

Your Health Profile

As a full spectrum Chiropractic Office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Childhood Years

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



Your Adult Years

	YES	NO	UNSURE	COMMENTS
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
On a scale of 1 – 10 describe your stress level (1 = none / 10 = extreme): Occupational _____ Personal _____				
On a scale of Poor-Good-Excellent describe your: Diet: _____ Exercise: _____ Sleep _____ General Health: _____				

Addressing the issues that brought you to this office

If you have no specific symptoms or complaints, and you are here for Chiropractic Wellness Services please (X) here _____ and skip to the Family Profile section of this form. All others please briefly describe your chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it... Sharp Dull Comes and goes Travels Constant
Since the problem started, it is... About the Same Getting Better Getting Worse

What makes it worse? _____

Does it interfere with... Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list):

Chiropractors _____

Medical Doctors _____

Others _____

Please check (X) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins and Needles in Leg | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fever | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Buzzing in Ear | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Menstrual Irritability | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Mood Swing | <input type="checkbox"/> Eyes Sensitive to Light |

List any medications you are now taking: _____

Family Health Profile

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your...

Children _____

Spouse / Partner / Significant Other _____

Parents _____

Siblings _____

Others _____

Do you:

Buy bottled water: YES NO Belong to a health club: YES NO Consume vitamins or supplements: YES NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature _____ Date _____