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 **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive 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	(Birth – Age 5)	Patient Comment (if answer is Yes)	Chiropractor's Comments
☐	☐	**1. Pregnancy**		
		Did your mother:		
☐	☐	Smoke or drink alcohol?		
☐	☐	Have a proper diet?		
☐	☐	Exercise through her pregnancy?		
☐	☐	Experience any falls and injuries during pregnancy?		
☐	☐	Experience any physical and/or mental abuse?		
		2. Birth Process		
☐	☐	Was the delivery long?		
☐	☐	Was the delivery difficult?		
☐	☐	Forceps?		
☐	☐	Caesarean?		
☐	☐	Breach/cephalic?		
☐	☐	Home birth?		
☐	☐	Hospital birth?		
☐	☐	Mother given drugs during delivery?		
☐	☐	Was labor induced?		
		3. Growth and Development		
☐	☐	Were you taught how to care for your spine?		
☐	☐	Did you roll out of bed?		
☐	☐	Were you a headbanger or rocker?		
☐	☐	Were you breast fed?		
☐	☐	Childhood sicknesses?		
☐	☐	Accidents?		
☐	☐	Surgery?		
☐	☐	Drugs?		
☐	☐	Did you fall while learning to walk?		
☐	☐	Were you picked on by siblings?		
☐	☐	Child abuse		
☐	☐	Spanking (how?)		
☐	☐	Pulled ear/chin		
☐	☐	Other		
☐	☐	Chair pulled out when sat down?		
☐	☐	Did you fall down stairs?		
☐	☐	Were you yanked by your arm?		
☐	☐	Did you have other traumas? What? When?		

Loss of Whole Body Health (Age 5 – present)

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

Yes	No	(Age 5 - Present)	Patient Comment (if answer is Yes)	Chiropractor's Comments
☐	☐	Were you taught proper body movement and care?		
☐	☐	Did/do you smoke?		
☐	☐	Did/do you drink any alcohol?		
☐	☐	Diet (Do you eat healthy foods?)		
☐	☐	Have you ever been in accidents?		
☐	☐	Have you had surgery and organs removed/replaced?		
☐	☐	Drugs? (Prescriptive or non-prescriptive)		
☐	☐	Teeth problems?		
☐	☐	Eye problems?		
☐	☐	Hearing problems?		
☐	☐	Exercise regularly?		
☐	☐	Sleeping habits (nightmares?)		
☐	☐	Did/do you have occupational stress?		
☐	☐	Physical stress?		
☐	☐	Mental stress?		
☐	☐	Hobbies/Sports injuries		
☐	☐	Other traumas or problems		

Symptoms and Ill Health (Present State of Ill Health)

Years of untreated damage showed up as acute or chronic symptoms.

Other Symptoms:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbess in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Buzzing in Ears

PRESENT COMPLAINT

Major complaint: _____

Pain or Problem started when: _____

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 (circle those that apply): Work? Sleep? Routine? Other: _____

Other doctors seen for this condition: _____

Any home remedies? _____

Symptoms and Ill Health (cont'd)

Have you been under drug and medical care? ☐ 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 the drugs and surgery?

_____

_____

_____

FAMILY HISTORY

Father's Side	Mother's Side
☐ Heart Disease	☐ Heart Disease
☐ Arthritis	☐ Arthritis
☐ Cancer	☐ Cancer
☐ Diabetes	☐ Diabetes
☐ Other: _____	☐ Other: _____

Patient Information

Name: _____ Social Security #: _____ Date: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ (Age: _____) If you were referred, by whom? _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

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

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

Nature of Accident: _____ When? _____

Did you feel a popping or tearing noise in your neck or back? ☐ Yes ☐ No

Did you require post-accident hospitalization? ☐ Yes ☐ No

Where? _____ When? _____ Were X-rays taken? ☐ Yes ☐ No

Did you lose days at work as a result? ☐ Yes ☐ No How many? _____

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

Attorney's name: ☐ n/a _____ Claim #: _____

Comments (office use only): _____

Email address: _____

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____ NO, I don't want to receive the Lambert Family Chiropractic e-newsletter.

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