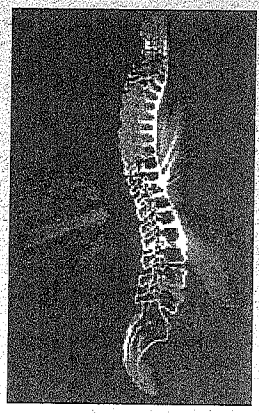
Case History



Fried Chiropractic Clinics

Prepared For:

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 thee 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?		
☐	☐	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 head banger or rocker?		
☐	☐	Were you breast fed?		
☐	☐	Childhood sicknesses?		
☐	☐	Surgery?		
☐	☐	Accidents?		
☐	☐	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?		
☐	☐	Diet (Do you eat healthy foods?)		
☐	☐	Have you ever been in an accident?		
☐	☐	Have you had surgery and organs removed/replaced?		
☐	☐	Drugs? (Prescriptive and 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 of Ill Health)

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

Other Symptoms:

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

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?

_____

_____

_____

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): _____

FRIED CHIROPRACTIC
1715 5th Ave
MOLINE, IL 61265

In accordance with the Patient Affordable Care Act of 2010, we are updating our records. Thank you for your cooperation.

Name_____ **Phone**_____

Address_____ **E-Mail**_____

City_____ **State**_____ **Zip Code**_____

Occupation_____ **Employer**_____

Date of Birth_____ **Sex M or F Right handed or Left handed(circle)**

FAMILY HISTORY	Disease in Family	Living or Deceased
	Arthritis, Heart disease,	
	Cancer, Diabetes,	
	Multiple Sclerosis	
MOTHER		
FATHER		
BROTHERS		
SISTERS		
GRANDMOTHERS		
GRANDFATHERS		

Please list ALL Surgeries	Year of Surgery

Please list any allergies to food, medication and other factors

Smoking Status:

Please check one:

____ Never a smoker

____ Current every day smoker _____ packs per day

____ Current periodic smoker. How often _____

____ Former Smoker. Quit in _____ year.

How many Children do you have? _____

Do you drink alcohol? _____ drinks per day/month (please circle)

Caffeine? How often? _____ How much? _____

Current Medications	**Dosage**

Signature _____

Date _____