Estero Family Chiropractic
Everyone needs a chiropractor on their health care team

21740 S. Tamiami Trail #103, Estero, FL, 33928
Esterofamilychiropractic.com
Ph: 239-676-9116
Fax:239-221-3959

CASE HISTORY

NAME_____DATE_____
ADDRESS_____Apt/Ste_____
CITY_____STATE_____ZIP_____
CELL PHONE(____)_____ DATE OF BIRTH_____ AGE_____
EMAIL: _____
REFERRED BY OR HOW YOU FOUND OUR OFFICE_____
OCCUPATION_____EMPLOYER_____
MARITAL STATUS: S M D W SPOUSES NAME_____
SPOUSES OCCUPATION_____NUMBER OF CHILDREN_____
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____YES ____NO
EMERGENCY CONTACT: _____ PHONE: (___)_____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health. This case history will uncover the layers of damage, especially to your nerve system, that 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.

LOSS OF WELLNESS

This case history starts from the beginning of your life up through present day. These injuries and misalignments may or may not have been painful. The longer they have been present the more time they have to grow in wrong.

YES	NO		PATIENT COMMENT If answer is YES	CHIROPRACTOR'S Comments
		1. YOUR BIRTH PROCESS		
_____	_____	Are you aware of any injuries during your birth process	_____	_____
_____	_____	Have you ever been diagnosed with Torticollis?	_____	_____
		2. THE REST OF YOUR LIFE		
_____	_____	Did you have broken bones	_____	_____
_____	_____	Did you have surgery?	_____	_____
_____	_____	Did/ do you drink any alcohol?	_____	_____
_____	_____	Diet (Do you eat healthy foods?)	_____	_____
_____	_____	Have you been in any auto accidents? If so when	_____	_____
_____	_____	Have you had surgery & organs removed/ replaced?	_____	_____
_____	_____	Did/ do you have scoliosis?	_____	_____
_____	_____	Did/ do you have physical stress?	_____	_____
_____	_____	Did/ do you have mental stress?	_____	_____
_____	_____	Do you currently smoke? If yes, how much?	_____	_____
_____	_____	Did/ do you have sports injuries?	_____	_____

PRIMARY REASON FOR CONSULTING OFFICE

Present complaint_____
Pain or problem started on_____
Pains are: _____SHARP _____DULL _____CONSTANT _____INTERMITTENT
Intensity: _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10
Frequency: _____Daily_____2-3 times weekly_____Sporadic
Is this condition worse at certain times of the day?
___Morning ___Afternoon ___Evening ___During sleep
Is this condition interfering with work?_____ sleep?_____ recreation?_____
self care_____walking_____sitting_____standing_____other?_____
Is this condition getting progressively worse?_____
Other doctors seen for this_____
Are you using any home remedies?_____

To ensure that we assist you achieving your health care goals:
Are you interested in Preventative and Wellness Care? Yes____No____

OTHER SYMPTOMS:

_____HEADACHES	_____PINS & NEEDLES IN LEGS	_____LOSS OF SMELL
_____NECK PAIN	_____NUMBNESS IN FINGERS	_____LOSS OF TASTE
_____SLEEPING PROBLEMS	_____NUMBNESS IN TOES	_____DIARRHEA
_____BACK PAIN	_____SHORTNESS OF BREATH	_____FEET COLD
_____NERVOUSNESS	_____FATIGUE	_____HANDS COLD
_____TENSION	_____DEPRESSION	_____STOMACH UPSET
_____IRRITABILITY	_____LIGHTS BOTHER EYES	_____CONSTIPATION
_____CHEST PAINS	_____LOSS OF MEMORY	_____COLD SWEATS
_____SLURRED SPEECH	_____HISTORY OF STROKES	_____ANEURYSMS
_____DIZZINESS	_____EARS RING	_____LOSS OF BALANCE
_____FACE FLUSHED	_____FEVER	_____BUZZING IN EARS
_____NECK STIFF	_____FAINTING	_____OSTEOPOROSIS
_____MUSCLE SPASMS	_____DOUBLE VISION	_____WEAKNESS IN ARMS/LEGS

Please list any current medications_____
_____
Are you interested in reducing the amount of medication you're on?____Yes____No
(If interested in Medical Marijuana let the doctor know)

Please list any known allergies_____

Is there a family history of?

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	Auto Immune
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

ABOUT YOUR CARE

Chiropractic provides two types of care. The first is **Relief**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Following the first phase of care, is **Wellness and Corrective Care**. It offers a genuine and natural approach maintain optimal physical, mental, and social well being! 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.

Dr. Signature_____Date_____