Dr. Jason White & Dr. Jarrod Bailey
1016 N Saginaw St, Suite C, Holly, MI 48442, 248-328-9800

Advanced Care Chiropractic
EXPERIENCE THE DIFFERENCE

CASE HISTORY

NAME_____DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

H. PHONE (____)_____W. PHONE(____)_____C. PHONE(___)_____

DATE OF BIRTH_____ AGE_____ EMAIL_____

SOCIAL SECURITY #_____ REFERRED BY_____

OCCUPATION_____EMPLOYER_____

MARITAL STATUS: S M D W SPOUSES NAME_____

SPOUSES OCCUPATION_____DATE OF BIRTH_____

NUMBER OF CHILDREN & AGES_____

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____YES ____NO

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

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

PATIENT COMMENT
(If answer is YES)

YES NO 1.BIRTH PROCESS

____ ____ Did your mother experience any falls & injury's during pregnancy?_____

_____ _____

____ ____ Was the delivery long? _____

____ ____ Was the delivery difficult? _____

____ ____ Forceps? _____

____ ____ Cesarean? _____

____ ____ Breach? _____

____ ____ Home birth? _____

____ ____ Hospital birth? _____

____ ____ Mother given drugs during delivery? _____

____ ____ Was labor induced? _____

YES NO 2. GROWTH AND DEVELOPMENT (BIRTH THROUGH TEEN YEARS)

____ ____ Were you taught how to care for your spine? _____

____ ____ Did you fall out of bed? _____

____ ____ Were you breast fed? _____

____ ____ Were you a head-banger or rocker? _____

____ ____ Were you picked on by siblings? _____

____ ____ Did you fall while learning to walk? _____

____ ____ Were you spanked? _____

____ ____ Did you experience child abuse? _____

____ ____ Chair pulled out when sat down? _____

____ ____ Did you have your ear/chin pulled _____

____ ____ Did you fall downstairs? _____

____ ____ Were you yanked by your arm? _____

____ ____ Did you have childhood sickness? _____

____ ____ Did you have accidents? _____

____ ____ Did you have surgery? _____

____ ____ Drugs? _____

____ ____ Did you have other traumas? _____

YES NO 3. LOSS OF WHOLE BODY HEALTH

____ ____ Were you taught proper body movement and care? _____

____ ____ Did/ do you smoke? _____

____ ____ Diet (Do you eat healthy foods?) _____

____ ____ Have you been in accidents? _____

____ ____ Have you had surgery & organs removed/ replaced? _____

____ ____ Did/ do you take drugs prescriptive or non-prescriptive? _____

_____

____ ____ Teeth problems? _____

____ ____ Eye problems? _____

____ ____ Hearing problems? _____

____ ____ Exercise regularly? _____

____ ____ Sleeping habits? _____

____ ____ Did/ do you have occupational stress? _____

____ ____ Did/ do you have physical stress? _____

____ ____ Did/ do you have mental stress? _____

____ ____ Did/ do you drink any alcohol? _____

____ ____ Did/ do you have sports injuries? _____

PRIMARY REASON FOR CONSULTING OFFICE

Finally, the years of continuing damage showed up as acute or chronic symptoms.

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 _____Constant

What activities aggravate your condition/pain? _____

Is condition worse certain times of the day? ___Morning ___Afternoon ___Evening ___Sleep

Is this condition interfering with work?_____ sleep?_____ routine?_____ other?_____

Is this condition getting progressively worse?_____ Other doctors seen for this_____

Are you using any home remedies? _____

OTHER SYMPTOMS:

_____BACK PAIN	____FATIGUE	____ NECK PAIN
_____BUZZ IN EARS	____FEVER	____NECK STIFF
_____CHEST PAINS	____FEET COLD	____NERVOUSNESS
_____COLD SWEATS	____HANDS COLD	____NUMBNESS IN HANDS
_____ CONSTIPATION	____HEADACHES	____NUMBNESS IN TOES
_____DEPRESSION	____IRRITABILITY	____PINS &NEEDLES IN ARM
_____DIARRHEA	____LIGHT BOTHER EYES	____PINS &NEEDLES IN LEG
_____DIZZINESS	____LOSS OF BALANCE	____SHORTNESS OF BREATH
_____EARS RINGS	____LOSS OF MEMORY	____SLEEPING PROBLEMS
_____FACE FLUSHED	____LOSS OF SMELL	____STOMACH UPSET
_____FAINTING	____LOSS OF TASTE	____TENSION
		____OTHER

SYMPTOMS

Have you been under medical care recently or for this problem?_____

Have you been taking prescriptive or non-prescriptive drugs?_____

Have you had surgery? _____Any side effects from drugs or surgery_____

Is there a family history of:

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Fathers **side**	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

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 **Reconstructive Care** begins 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**. At that time you'll be able to begin a course of care that fits your health goals.

Dr. Signature_____Date_____