

# SMITH UCHC CASE HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

H. PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ WK: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

MARITAL STATUS: S M D W REFERRED BY: \_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_ NUMBER OF CHILDREN \_\_\_\_\_ PREGNANT:  Y  N

EMAIL: \_\_\_\_\_ PREVIOUS CHIROPRACTIC CARE?  Y  N

OCCUPATION / EMPLOYER: \_\_\_\_\_

## ABOUT YOUR HEALTH

THE HUMAN BODY IS DESIGNED TO BE HEALTHY. THROUGHOUT LIFE, EVENTS OCCUR THAT CAN DAMAGE YOUR HEALTH EXPRESSION. THIS CASE HISTORY WILL UNCOVER THE LAYERS OF DAMAGE, ESPECIALLY TO YOUR NERVOUS SYSTEM THAT RESULTED IN POOR HEALTH. FOLLOWING YOUR EXAM YOUR DOCTOR WILL OUTLINE A COURSE OF CARE THAT WILL BEGIN TO CORRECT THE LAYERS OF DAMAGE AND RECOVER YOUR INNATE HEALTH POTENTIAL.

## PRESENT STATE OF HEALTH

PRESENT COMPLAINT (BE BRIEF) \_\_\_\_\_

PAIN OF PROBLEMS STARTED ON (DATE) \_\_\_\_\_

PAINS ARE:  SHARP  DULL  CONSTANT  ACHY

WHAT ACTIVITIES MAKE YOUR PAIN / CONDITION WORSE? \_\_\_\_\_

IS THIS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? \_\_\_\_\_

IS THIS CONDITION INTERFERING WITH: WORK? \_\_\_\_\_ SLEEP? \_\_\_\_\_ NORMAL ROUTINE? \_\_\_\_\_

IS THIS CONDITION GETTING PROGRESSIVELY WORSE?  Y  N

OTHER DOCTORS SEEN FOR THIS CONDITION? \_\_\_\_\_

ANY HOME REMEDIES? \_\_\_\_\_

OTHER PROBLEMS: \_\_\_\_\_

HAVE YOU BEEN UNDER MEDICAL CARE?  Y  N REASON: \_\_\_\_\_

WHAT MEDICATIONS ARE YOU TAKING? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

WHAT SIDE EFFECTS HAVE YOU EXPERIENCED FROM THE MEDICATIONS AND OR SURGERIES? \_\_\_\_\_

# HEALTH HISTORY

YES	NO	CURRENT HEALTH
<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU BEEN IN ANY ACCIDENTS?
<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU HAD ANY SURGERIES?
<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU HAD ANY TEETH PROBLEMS?
<input type="checkbox"/>	<input type="checkbox"/>	EYE PROBLEMS?
<input type="checkbox"/>	<input type="checkbox"/>	HEARING PROBLEMS?
<input type="checkbox"/>	<input type="checkbox"/>	EXERCISE REGULARLY?
<input type="checkbox"/>	<input type="checkbox"/>	DO / DID YOU HAVE ANY PHYSICAL STRESS?
<input type="checkbox"/>	<input type="checkbox"/>	DO / DID YOU HAVE ANY MENTAL STRESS?
<input type="checkbox"/>	<input type="checkbox"/>	DO / DID YOU SMOKE?
<input type="checkbox"/>	<input type="checkbox"/>	DO / DID YOU DRINK ALCOHOL?

**OTHER SYMPTOMS: (CHECK ALL THAT APPLY)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> HEADACHES<br><input type="checkbox"/> NECK STIFFNESS<br><input type="checkbox"/> NECK PAIN<br><input type="checkbox"/> BACK PAIN<br><input type="checkbox"/> SHORTNESS OF BREATH<br><input type="checkbox"/> CHEST PAINS<br><input type="checkbox"/> IRRITABILITY<br><input type="checkbox"/> UPSET STOMACH<br><input type="checkbox"/> CONSTIPATION<br><input type="checkbox"/> DIARRHEA<br><input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> PINS & NEEDLES IN ARMS<br><input type="checkbox"/> PINS & NEEDLES IN LEGS<br><input type="checkbox"/> NUMBNESS IN FINGERS<br><input type="checkbox"/> NUMBNESS IN TOES<br><input type="checkbox"/> LOSS OF BALANCE<br><input type="checkbox"/> ALLERGIES<br><input type="checkbox"/> RINGING IN EARS<br><input type="checkbox"/> SENSITIVE TO LIGHT<br><input type="checkbox"/> LOSS OF MEMORY<br><input type="checkbox"/> LOSS OF TASTE<br><input type="checkbox"/> HEAD FEELS TOO HEAVY | <input type="checkbox"/> FAINTING<br><input type="checkbox"/> COLD SWEATS<br><input type="checkbox"/> FEVER<br><input type="checkbox"/> DIZZINESS<br><input type="checkbox"/> COLD HANDS<br><input type="checkbox"/> COLD FEET<br><input type="checkbox"/> FATIGUE<br><input type="checkbox"/> TENSION<br><input type="checkbox"/> DEPRESSION<br><input type="checkbox"/> LOSS OF SMELL<br><input type="checkbox"/> NERVOUSNESS |
|--|--|---|

NAME OF PERSON RESPONSIBLE FOR PAYMENT \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (     ) \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

ARE YOU INSURED?  YES  NO

COMPANY: \_\_\_\_\_ PHONE: (     ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

## CARE PROGRAM

THE PURPOSE OF STRAIGHT CHIROPRACTIC CARE AT THIS OFFICE CONSISTS OF THE DETECTION, LOCATION AND CORRECTION OF THE VERTEBRAL SUBLUXATION, WHICH PRODUCES INTERFERENCE ON THE BRAIN STEM AND OR SPINAL CORD AND NERVES. THERE ARE THREE PHASES OF CARE. THE FIRST IS THE *RELIEF PHASE*, WHICH CORRECTS THE MOST RECENT LAYER OF SPINAL AND NEUROLOGICAL DAMAGE. THIS PHASE USUALLY REDUCES OR ELIMINATES THE SYMPTOMS. THEN BEGINS THE *CORRECTION PHASE*, WHICH CORRECTS THE YEARS OF DAMAGE THAT OCCURRED WHEN THERE WERE FEW SYMPTOMS. FINALLY WE OFFER A GENUINE APPROACH TO *WELLNESS CARE* (ALSO KNOWN AS THE *STRENGTHENING PHASE*), WHICH IS LONG TERM AND MOST BENEFICIAL. 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. NO DIAGNOSIS, TREATMENT OR CURING OF DISEASE IS OFFERED AT THIS OFFICE. I ACCEPT CHIROPRACTIC CARE ON THIS BASIS ALONE.

**PLEASE SIGN BELOW TO INDICATE THAT ALL INFORMATION PROVIDED IS ACCURATE AND THOROUGH.**

SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_