SMITH UCC CASE HISTORY

NAME: _____ **DATE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP:** _____

H. PHONE: _____ **CELL:** _____ **WK:** _____

DATE OF BIRTH: _____ **AGE:** _____ **PREVIOUS CHIROPRACTIC CARE?** ❑ **YES** ❑ **NO**

MARITAL STATUS: **S M D W** **REFERRED BY:** _____

SPOUSES NAME: _____ **NUMBER OF CHILDREN**_____ **PREGNANT:** ❑**Y** ❑**N**

EMAIL: _____

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 MAKEYOUR 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 AFFECTS HAVE YOU EXPERIENCED FROM THE MEDICATIONS AND OR SURGERIES? _____

_____

HEALTH HISTORY

YES	NO	CURRENT HEALTH
❑	❑	HAVE YOU BEEN IN ANY ACCIDENTS?
❑	❑	HAVE YOU HAD ANY SURGERIES?
❑	❑	HAVE YOU HAD ANY TEETH PROBLEMS?
❑	❑	EYE PROBLEMS?
❑	❑	HEARING PROBLEMS?
❑	❑	EXERCISE REGULARLY?
❑	❑	DO / DID YOU HAVE ANY PHYSICAL STRESS?
❑	❑	DO / DID YOU HAVE ANY MENTAL STRESS?
❑	❑	DO / DID YOU SMOKE?
❑	❑	DO / DID YOU DRINK ALCOHOL?

OTHER SYMPTOMS: (CHECK ALL THAT APPLY)

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

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____

ADDRESS: _____**CITY:** _____

STATE: _____ **ZIP:** _____**PHONE:** ( ) _____ **CELL:** ( ) _____

CARE PROGRAM

THE PURPOSE OF UPPER CERVICAL 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:** _____