ALTERNATIVE HEALING CHIROPRACTIC CENTER
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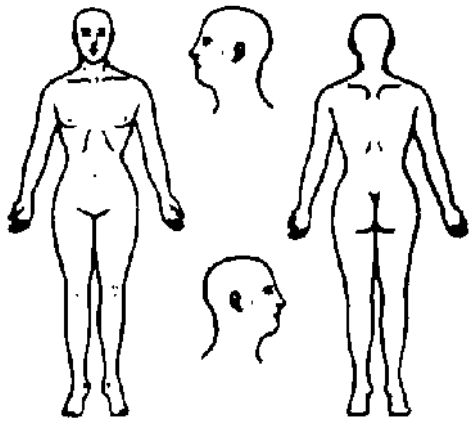
CASE HISTORY

Name: _____

Please Circle Your Areas Of Pain On The Figures:

Please Mark:
A = Ache
B = Burn
S = Sharp/Stab
N = Numb
T = Tingling



- What is your major complaint? _____
- How did it happen?_____
- Have you had this or similar conditions in the past? ☐ Yes ☐ No
- Onset: When did you first notice your current symptoms? _____
- Describe your pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Stiff ☐ Stabbing ☐ Shooting ☐ Pins & Needles ☐ Numbness ☐ Other: _____
- Is it: ☐ Constant ☐ Intermittent Is this condition getting progressively worse? ☐ Yes ☐ No
- What **aggravates** your condition? ☐ Sitting ☐ Standing ☐ Driving ☐ Gardening ☐ Exercise ☐ House-hold Chores ☐ Walking ☐ Bending ☐ Reading ☐ Twisting ☐ Lifting ☐ Cough/Sneeze ☐ Paperwork ☐ Computer Work ☐ Lying Down ☐ Other: _____
- What makes your condition **feel better**? ☐ Heat ☐ Ice ☐ Medication ☐ OTC ☐ Massage ☐ Stretching ☐ Exercise ☐ Lying Down ☐ Walking ☐ Standing ☐ Other: _____
- Other doctors who treated this condition: _____
- Previous X-Ray, MRI or other diagnostic tests: _____
- List major accidents or injuries and year: _____
- List major surgeries and year: _____

_____

- Please list all major illnesses and/or diseases (e.g. cancer, diabetes, heart disease, etc.) that you currently have or have had in the past: _____

Habits (Please Check):	Moderate	Occasional	None	How Often/How Much?
Alcohol	☐	☐	☐	_____
Caffeine	☐	☐	☐	_____
Exercise habits	☐	☐	☐	_____

What type of exercise: _____

Recent weight loss not related to diet or nutritional changes? _____

- **Review of Systems:** Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check any condition that you've **Had** or currently **Have.**

Musculoskeletal

Had	Have	
☐	☐	Osteoporosis
☐	☐	Arthritis
☐	☐	Scoliosis
☐	☐	Knee Injuries
☐	☐	Shoulder Problems
☐	☐	Neck Pain
☐	☐	Back Pain
☐	☐	Hip Disorders
☐	☐	Foot/Ankle Pain
☐	☐	Elbow/Wrist Pain
☐	☐	TMJ Issues

Sensory

☐	☐	Blurred Vision
☐	☐	Ringing in Ears
☐	☐	Loss of Smell
☐	☐	Loss of Taste

Neurological

Had	Have	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Headache
☐	☐	Dizziness
☐	☐	Pins & Needles
☐	☐	Numbness

Cardiovascular

☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Excessive Bruising

Skin

☐	☐	Skin Cancer
☐	☐	Psoriasis
☐	☐	Eczema
☐	☐	Rash

Respiratory

Had	Have	
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Hay Fever
☐	☐	Shortness of Breath

Digestive

☐	☐	Anorexia/Bulimia
☐	☐	Ulcer
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn

Endocrine

☐	☐	Thyroid Issues
☐	☐	Hypoglycemia
☐	☐	Diabetes
☐	☐	Immune Disorders:

_____

- **Family History:** Some health issues are hereditary. Please let Dr. Loudenbeck and Dr. Stauss know about the health of your immediate family members.

Relative	Age (If Living)	State of Health		Illnesses	Age at Death	Cause of Death	
		Good	Poor			Natural	Illness
Mother	_____	☐	☐	_____	_____	☐	☐
Father	_____	☐	☐	_____	_____	☐	☐
Sister 1	_____	☐	☐	_____	_____	☐	☐
Sister 2	_____	☐	☐	_____	_____	☐	☐
Brother 1	_____	☐	☐	_____	_____	☐	☐
Brother 2	_____	☐	☐	_____	_____	☐	☐

- Are there any other hereditary health issues that you know about? _____

_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ Date: _____