Case History

Name: _____ Date: _____

Address: _____

City: _____ Postal Code: _____ Status: M S W D Sex: M F

Birthdate: _____ | _____ | _____ Age: _____ Family Doctor: _____
Day Month Year

Spouse's Name: _____ Ages of Children: _____

Work/Occupation: _____ Telephone: _____

Referred by: _____ Email: _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health and expression. This case history will help to uncover the layers of damage, especially to your spine and nervous system, that have resulted in a lowered state of health. Following the evaluation, your chiropractor will indicate if he can help you and to what extent.

Area of Concern

What is your major complaint presently? _____

When did it most recently begin? _____

What activity, if any, caused it to occur? _____

Have you had any previous occurrences?
Please describe. _____

Did this health problem develop from a specific cause or injury? _____

What provokes this problem? _____

What alleviates this problem? _____

Is this problem: ☐ Worsening ☐ Improving ☐ The Same

Describe the symptom (i.e. burning, sharp, etc.) _____

Does this problem affect your: ☐ Work ☐ Home ☐ Recreation ☐ Sleep

Previous diagnosis: _____

Previous treatment:

Secondary Area of Concern

What is your major complaint presently? _____

When did it most recently begin? _____

What activity, if any, caused it to occur? _____

Have you had any previous occurrences?
Please describe. _____

Did this health problem develop from a specific cause or injury? _____

What provokes this problem? _____

What alleviates this problem? _____

Is this problem: ☐ Worsening ☐ Improving ☐ The Same

Describe the symptom (i.e. burning, sharp, etc.) _____

Does this problem affect your: ☐ Work ☐ Home ☐ Recreation ☐ Sleep

Previous diagnosis: _____

Previous treatment: _____

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TEL: 905.892.877 | FAX: 905.892.8788 | WEB: www.cometothesummit.com

Your Health History

Have you received chiropractic care before? ☐ Yes ☐ No When: _____

Where? _____ For what condition: _____

What medications do you take?

Name of Medication	Used For	Name of Medication	Used For

What surgeries have you had?

Surgery	Approximate Year	Surgery	Approximate Year

What motor vehicle accidents have you experienced?

Most recent (year): _____ Type of Collision: ☐ Rear Ended ☐ Head On ☐ Side Impact ☐ Roll Over

Injuries: _____ For: _____

Most recent (year): _____ Type of Collision: ☐ Rear Ended ☐ Head On ☐ Side Impact ☐ Roll Over

Injuries: _____ For: _____

Most recent (year): _____ Type of Collision: ☐ Rear Ended ☐ Head On ☐ Side Impact ☐ Roll Over

Injuries: _____ For: _____

Do not fill in this area (WO)

(SP)

(HO)

Do you currently suffer from any of these, or other, serious conditions? Briefly describe.

1st Arthritic	No ☐	Yes		2nd Arthritic	No ☐	Yes	
Cancer	No ☐	Yes		Cancer	No ☐	Yes	
Infection	No ☐	Yes		Infection	No ☐	Yes	
Vascular	No ☐	Yes		Vascular	No ☐	Yes	
Blood Pressure	No ☐	Yes		Blood Pressure	No ☐	Yes	
1st Other	No ☐	Yes		2nd Other	No ☐	Yes	

In the PAST have you experienced these or any other major health problems?

1st Arthritic	No ☐	Yes		2nd Arthritic	No ☐	Yes	
Cancer	No ☐	Yes		Cancer	No ☐	Yes	
Infection	No ☐	Yes		Infection	No ☐	Yes	
Vascular	No ☐	Yes		Vascular	No ☐	Yes	
Blood Pressure	No ☐	Yes		Blood Pressure	No ☐	Yes	
1st Other	No ☐	Yes		2nd Other	No ☐	Yes	