



Inner Movement

Chiropractic Massage Acupuncture Detoxification Holistic Medical

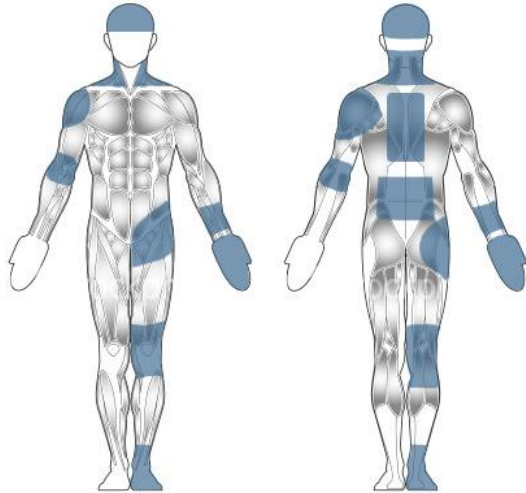
Name _____ E-mail _____ Date _____
 Address _____ City _____ State _____ Zip _____
 H. Phone (____) _____ Cell# (____) _____ W. Phone (____) _____ D.O.B. _____ Age _____
 Referred by _____ Social Security # _____
 Occupation _____ Employer _____
 Marital Status S M D W Spouses Name _____
 Are you pregnant? What week? _____ Number of Children and Ages _____
 Have you ever received Chiropractic Care? Yes No Within 1 year Over 1 year Did you have a good experience? Yes No
 Have you ever received Massage Therapy Before? Yes No Within 1 year Over 1 year Did you have a good experience? Yes No

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage that have resulted in poor health & brought you here today.

		Patient Comment if answer is Yes	Chiropractor's Comments
Yes	No		
1. When you were Born 2. When you gave birth			
<input type="checkbox"/>	<input type="checkbox"/>	1a. Did your mother complain of a difficult delivery?	
<input type="checkbox"/>	<input type="checkbox"/>	1b. Were you born with Forceps or Caesarean?	
<input type="checkbox"/>	<input type="checkbox"/>	2a. Number of Vaginal Deliveries?	
<input type="checkbox"/>	<input type="checkbox"/>	2b. Number of Caesarean Deliveries?	
<input type="checkbox"/>	<input type="checkbox"/>	2c. Pain during past pregnancy? Where?	
<input type="checkbox"/>	<input type="checkbox"/>	2d. Complications during past pregnancy?	
<input type="checkbox"/>	<input type="checkbox"/>	2e. If pregnant, pain during this pregnancy? Where?	
<input type="checkbox"/>	<input type="checkbox"/>	2f. If pregnant, complications during this pregnancy?	
2. Growth and Development (1-18 y/o)			
<input type="checkbox"/>	<input type="checkbox"/>	Did you have head injuries as a child?	
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall out of bed? Fall downstairs?	
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic childhood sicknesses?	
<input type="checkbox"/>	<input type="checkbox"/>	Childhood car accidents?	
<input type="checkbox"/>	<input type="checkbox"/>	Physical Child abuse?	
<input type="checkbox"/>	<input type="checkbox"/>	Emotional stress during childhood?	
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? (i.e. sports injuries)	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery / stitches?	
3. Current Health Habits			
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke? Drink? #per day	
<input type="checkbox"/>	<input type="checkbox"/>	Diet (outline typical Breakfast, Lunch, Dinner)	
<input type="checkbox"/>	<input type="checkbox"/>	Do you take Multivitamin <input type="checkbox"/> Omega 3 <input type="checkbox"/> Probiotic <input type="checkbox"/> Other?	
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise?	
<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep well? Hours? Side <input type="checkbox"/> Back <input type="checkbox"/> Stomach <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have Physical Stress? (rate on 1 to 10 scale)	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have Mental Stress? (rate on 1 to 10 scale)	

Yes	No	Injuries as an Adult
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in car accidents as an adult?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced?
<input type="checkbox"/>	<input type="checkbox"/>	Sports injuries as an adult?
<input type="checkbox"/>	<input type="checkbox"/>	Falls as an adult?
<input type="checkbox"/>	<input type="checkbox"/>	Other?



PLEASE MARK YOUR AREA(S) OF PAIN

Have you been under drug and medical care?
What medications are you taking?

Have you had an Xray/MRI in past 3 years?
Have you had blood testing/regular checkup?

Is there a family history of:

Heart Disease Cancer Diabetes
 Arthritis Other

Symptom(s) that brought you to us?

Years of continuing damage eventually show up as acute or chronic symptoms.

Present Complaint (be brief)

Major

Pain or Problem started?

Previous Episodes?

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain?

What activities lessen your condition/pain?

Is condition worse during certain times of the day?

Is this condition interfering with work? Sleep? Routine? Other?

Is condition getting progressively worse?

Other Doctors seen for this condition

Other symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting/Nausea |
| <input type="checkbox"/> Neck Pain/Tension | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Back Pain/Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Disc Problems |
| <input type="checkbox"/> Pain w/ sneeze or cough | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Pain w/ standing (from sitting) | <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Diabetes/frequent urination | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer/sudden weight loss | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Circulatory Conditions | <input type="checkbox"/> Infections | <input type="checkbox"/> Other _____ |

About Us: We want to give people more miracles that become the standard of care. We believe integrative health is the way to do that.