Gelardi Chiropractic

Confidential Case History

Date _____

Mr/Mrs/Ms/
Miss/Dr/Rev/_____ Name _____ Date of Birth _____ Age _____

Mobile Phone _____ Texting? Yes / No Email _____

Home Address _____ City/St _____ Zip _____

Children's Ages _____ Employer/Occupation _____ **M / F** **S**ingle / **M**arried / **D**iv / **S**ep / **W**id

Who may we thank for referring you? _____ Date of last chiropractic care?_____

Reasons For Seeking Chiropractic Care: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Major Concern started on _____ Is this related to an accident? **Yes** **No** Recent X-Rays of Spine? _____

Since it began, is it: ☐ Same ☐ Better ☐ Worst _____

What activities aggravate your condition? _____

What activities lessen your condition? _____

Is this condition interfering with: Work?_____ Sleep?_____

Routine?_____ Other? _____

Other Doctors seen for this condition _____

_____

If your reason for care is pain, use this section to describe & mark your pain.

Mark on the pictures where you feel pain & label

N - Numbness **A** - Dull Ache **B** - Burning

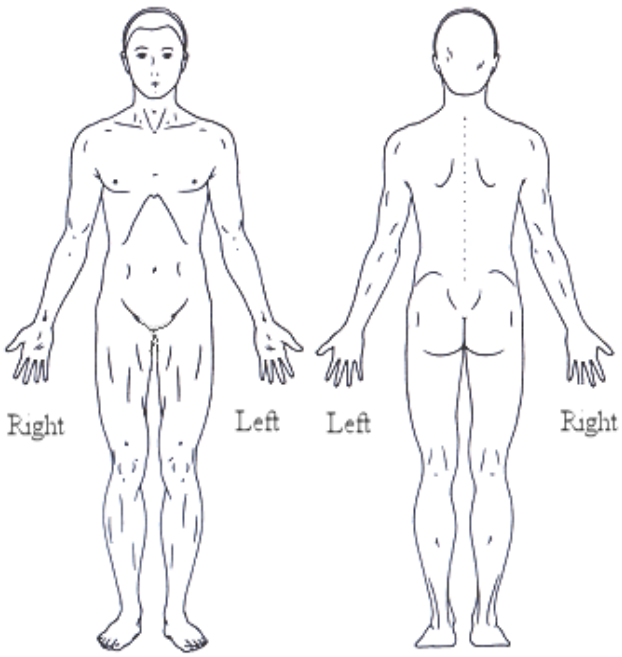
S - Sharp/Stabbing **T** - Tingling

other _____

Pains are: ☐ Constant ☐ Intermittent ☐ Other

Pain shoots, radiates, or travels in your body? Where?

_____



 Name _____ Date _____

Your Accident History is IMPORTANT. Throughout your life, what accidents have you had?

Injuries from sports? **Auto accidents *ever***? Other traumas, childhood, falls...?

Please include: DATE, DESCRIPTION of Impact, INJURIES, and whether the injuries have healed or are current.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did you ever **break any bones**? _____

Please list all current MEDICATIONS.	Date started this/similar drug	Med is for what condition?	Do you have any side effects?	Daily or PRN (as needed)

Any significant PAST medications not listed above?

History of significant use of ANTIBIOTICS?

 Name _____ Date _____

DATE	**S**URGERY or **H**OSPITILIZATION	REASON / DESRIPTION
	S H	
	S H	
	S H	
	S H	
	S H	
	S H	
	S H	
	S H	
	S H	

Mark Your Condition (if there are multiple issues on a line)	Current Past Never	Additional Information
CURRENTLY CONTAGIOUS ? *Airborne, skin, lice, bed bugs?*	**Yes No**	
Allergies/ Sinus Problems	**C P N**	
Asthma/ Difficulty Breathing	**C P N**	
Arthritis/ Rheumatoid A	**C P N**	
Chronic Fatigue/ Lupus / Fatigue	**C P N**	
Fibromyalgia/ Anemia	**C P N**	
Cancer/ Chemotherapy	**C P N**	
HIV+/ AIDS	**C P N**	
Hepatitis _____ (B or C)	**C P N**	
Other Immune Weakness	**C P N**	
Rheumatic Fever/ Frequent Fever	**C P N**	
Pneumonia/ Bronchitis	**C P N**	
PREGNANT / Menopause	**C P N**	
Menstrual/ Fertility Problems	**C P N**	
Thyroid _____	**C P N**	
High/ Low … Blood Pressure	**C P N**	
High Cholesterol	**C P N**	
Cold Hands/Feet / Leg Cramps	**C P N**	
Diabetes / Hypoglycemia	**C P N**	
Fainting/ Dizziness	**C P N**	
Seizures/ Epilepsy	**C P N**	
Heart Problems/Heart Attack	**C P N**	
Severe/Frequent Headaches	**C P N**	
Stroke (TIA)	**C P N**	

 Name _____ Date _____

Mark Your Condition (if there are multiple issues on a line)	Current Past Never	Additional Information
Kidney Problems/Painful Urination	**C P N**	
Reflux/irritable bowel/ulcer	**C P N**	
Upset Stomach / Heartburn	**C P N**	
Constipation / Diarrhea	**C P N**	
Osteoporosis	**C P N**	
Tuberculosis	**C P N**	
Emphysema/ Glaucoma	**C P N**	
Artificial Bones/ Joints	**C P N**	
Emotional/Mental Stress	**C P N**	
Depression / Anxiety / _____	**C P N**	
Alcohol/ Drug Abuse	**C P N**	
Did/ do you smoke?	**C P N**	
Eye Problems	**C P N**	
Hearing Problems/ Loss of Balance	**C P N** **C P N**	
Ringing in Ears	**C P N**	
Dental Problems / Braces	**C P N**	
Sleep Problems	**C P N**	
Physical Stress?	**C P N**	
Neck Pain/Stiff (chronic/acute)	**C P N**	
Low Back Pain (chronic/acute)	**C P N**	
Mid Back Pain (chronic/acute)	**C P N**	
Shoulder Pain/ Stiffness	**C P N**	
Numbness/Pain in Legs/ Feet	**C P N**	
Numbness/Pain in Arms/Hands	**C P N**	
Joint Swelling	**C P N**	
Jaw/TMJ Problems	**C P N**	
Loss of Memory / Loss of Hair	**C P N**	
Weight Loss/Loss of Smell/Loss of Taste	**C P N**	
Other	**C P N**	
Regarding <u>YOUR</u> Birth and Childhood:		
Long/difficult delivery	**P N**	
Forceps or extraction used	**P N**	
C-Section	**P N**	
Breach	**P N**	
Hospital (vs home) birth	**P N**	
Mother given drugs in delivery	**P N**	
Labor induced	**P N**	
Bottle fed (versus breastfed)	**P N**	
Ear infections/ Colic	**C P N**	
Attention Deficit	**C P N**	

Do you consume (more than 3 times a month):

☐ cigarettes ☐ city water ☐ sodas ☐ artificial sweeteners ☐ alcohol ☐ fast food ☐ _____

Do you DRIVE a lot? If yes, how much daily drive time? _____

Balanced DIET (with daily vegetables & healthy fats & protein)? ☐ Yes ☐ No

Do you get regular sunshine? ☐ Yes ☐ Some ☐ Barely ☐ No

Do you SLEEP at least 7 to 8 hours? ☐ Yes ☐ No If no, ☐ insomnia, ☐ busy, ☐ don't need it.

Do you EXERCISE on most days? ☐ Yes ☐ No

Terms of Acceptance:

Chiropractic is based on the premise that living things have an inborn striving to maintain their own health. A subluxation is a slightly misaligned spinal bone which interferes with the transmission of mental impulses over the nerves and reduces the body's natural ability to maintain its own health. The chiropractor's one goal is to periodically examine the patient's spine and should a subluxation be detected, correct it by means of a chiropractic adjustment. This re-establishes more normal nerve function. The chiropractor does not diagnose or treat disease. The chiropractic examination and adjustment are not a substitute for other types of health care, just as other types of health care do not take the place of chiropractic. I have read and understand the above.

*signed*_____*date*_____

Parental Release:

I,_____, parent or legal guardian of _____,

give my permission for him/her to receive chiropractic care.

*signed*_____ *date* _____

Parental Permission for Photo:

Do NOT sign this at the start of care. We will ask you later.

I, _____, give my permission for an un-named photo of

_____ to be included in a "Chiropractic Kid's Poster" that hangs inside the office.

signed _____ *date* _____

Auto Injury Insurance:

We do not accept "accident cases." We are happy to give anyone chiropractic care *(for correction of Spinal Subluxations).* But, we do not: 1) relate care to an injury, 2) transcribe records into paragraphs or reports, 3) provide itemized billing statements (you are given a receipt on each visit with itemized coded procedures for health insurance and HSA), nor do we 4) offer expert witness testimony.