Gelardi Chiropractic

Confidential Case History

Date ____________________

Mr/Mrs/Ms/Miss/Dr/Rev/______ Name ____ Date of Birth ________________ Age _______

Cell Phone _________________________ Texting? Yes/No M / F **S**ingle/**M**arried/**D**iv/**S**ep/**W**idowed Children's Ages ____________________

Home Phone _______________________ Work Phone ________________________ Employer ___________________________________

Address ___________________________________ City/St ____________________ Zip _________ Occupation ____________________

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

EMAIL

Reasons For Seeking Chiropractic Care: ____

____

____ *(use blank space at the bottom to write more)*

Major Health Concern, Symptom, Pain or Problem started on __________________________ | Recent X-Rays of Spine? ________________

Since it began, is it: ☐ Same ☐ Better ☐ Worst Is this condition progressively getting worse?___________________________

What activities aggravate your condition/pain?____

What activities lessen your condition/pain?____

Is this condition worse during certain times of the day?____

Is this condition interfering with Work?_________ Sleep?_________Routine?_______Other?________________________________

Other Doctors seen for this condition____

Any home remedies? ____

Please Circle where you are at: ("0" = good) 0 1 2 3 4 5 6 7 8 9 10 ("10" = Worst Possible Complaint, Symptom , Pain)

If your complaint is pain, use this section to describe and mark your pain.

Pains are: ☐ Sharp ☐ Dull/ Ache ☐ Constant ☐ Intermittent ☐ Other ______

Does this pain shoot, radiate, or travel in your body? Where? ______________

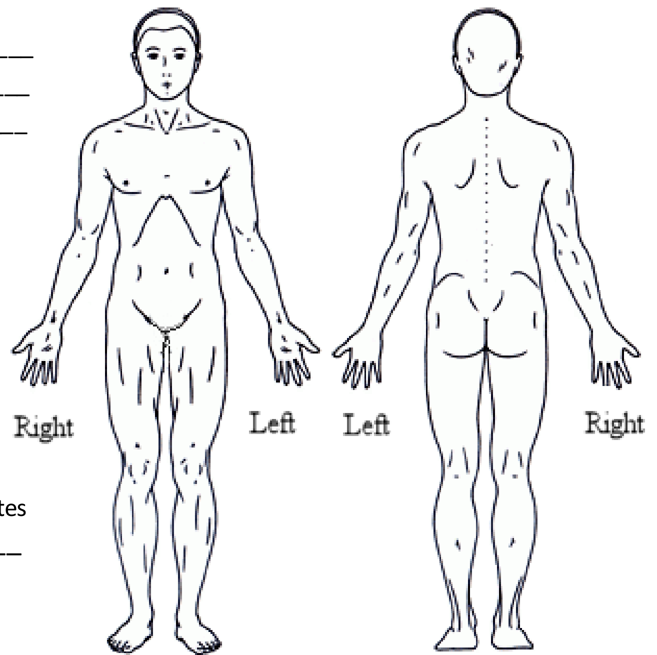
Are you experiencing numbness/tingling in any area of your body? __________

Mark on the pictures where you feel pain and label with a number below.

(1) Numbness (4) Sharp/Stabbing

(2) Dull Ache (5) Pins, Needles

(3) Burning (6) Other ________



Injuries during sports? Y N ______________________________________

Auto accidents? Y N ____

____

Did you have other traumas? Y N _______________________________

Did you ever break any bones? Y N _____________________________

Do you consume (more than 3 times a month): ☐ city water ☐ sodas ☐ cigarettes ☐ artificial sweeteners ☐ alcohol ☐ fast food ☐ OTHER ____________________

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

Do you eat vegetables daily? ☐ Yes ☐ No Organic? ☐ Yes ☐ No

Balanced diet (with healthy fats & protein)? ☐ Yes ☐ No

Do you eat protein before 11am? ☐ Yes ☐ No

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

Do you sleep at least 7 to 8 hours? ☐ Yes ☐ No

Do you exercise on most days? ☐ Yes ☐ No

	Please mark any conditions you have had now or in the past.	Current/ Past		Make comments here
1	Allergies/ Sinus Problems	C	P	
2	Asthma/ Difficulty Breathing	C	P	
3	Arthritis/ Rheumatoid A	C	P	
4	Chronic Fatigue/ Lupus / Fatigue	C	P	
5	Fibromyalgia/ Anemia	C	P	
6	Cancer/ Chemotherapy	C	P	
7	HIV+/ AIDS	C	P	
8	Other Immune Weakness	C	P	
9	Rheumatic Fever / Frequent Fever	C	P	
10	Pneumonia/ Bronchitis	C	P	
11	Menstrual/ Fertility Problems	C	P	
12	**PREGNANT** / Menopause	C	P	
13	Thyroid _______________	C	P	
14	High/ __ Low … Blood Pressure	C	P	
15	High Cholesterol	C	P	
16	Cold Hands/Feet / Leg Cramps	C	P	
17	Diabetes / Hypoglycemia	C	P	
18	Fainting/ Dizziness	C	P	
19	Seizures/ Epilepsy	C	P	
20	Heart Problems/Heart Attack	C	P	
21	Severe/Frequent Headaches	C	P	
22	Stroke (TIA)	C	P	
23	Kidney Problems/ Painful Urination	C	P	
24	Reflux/irritable bowel/ulcer	C	P	
25	Upset Stomach / Heartburn	C	P	
26	Constipation / Diarrhea	C	P	
27	Osteoporosis	C	P	
28	Tuberculosis	C	P	
29	Emphysema/ Glaucoma	C	P	
30	Artificial Bones/ Joints	C	P	
31	Hepatitis _____ (B or C)	C	P	
32	CURRENTLY CONTAGIOUS	C	P	

	Please mark any conditions you have had now or in the past.	Current/ Past	
33	Emotional/Mental Stress	C	P
34	Depression / Anxiety / ________	C	P
35	Alcohol/ Drug Abuse	C	P
36	Did/ do you smoke?	C	P
37	Sleep Problems	C	P
38	Eye Problems	C	P
39	Hearing Problems/Loss of Balance	C	P
40	Ringingin Ears	C	P
41	Dental Problems / Braces	C	P
42	Physical Stress?	C	P
43	Neck Pain/Stiffness (chronic/acute)	C	P
44	Low Back Pain (chronic/acute)	C	P
45	Mid Back Pain (chronic/acute)	C	P
46	Shoulder Pain	C	P
47	Numbness/Pain in Legs/ Feet	C	P
48	Numbness/Pain in Arms/Hands	C	P
49	Joint Swelling	C	P
50	Jaw/TMJ Problems	C	P
51	Loss of Memory / Loss of Hair	C	P
52	Weight Loss/Loss of Smell or Taste	C	P
	Regarding Your Birth Process and Childhood:		
53	Long/difficult delivery		P
54	Forceps or extraction used		P
55	C-Section		P
56	Breach		P
57	Hospital (vs home) birth		P
58	Mother given drugs during delivery		P
59	Labor induced		P
60	Bottle fed (versus breastfed)	C	P
61	Ear infections/ Colic	C	P
62	Attention Deficit	C	P
63	**OTHER:** ____________________	C	P

Please list all current medications.	Date started this or similar drug	Med is for what condition? Do you have any side effects?	Daily/PRN (as needed)	Have you had any Surgeries? Or Hospitalizations? When?

Have you used antibiotics in the past 3 years? ☐ Yes ☐ No Have you used antibiotics significantly at any time in your life? ☐ Yes ☐ No

Any significant past medications not listed above?____

Is there a family history of: ☐ Heart Disease ☐ Cancer ☐ Arthritis ☐ Diabetes ☐ Other ___________________________________

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 Terms of Acceptance. ***signed***____*date*________________

Parental Release: I,___________________________________, parent or legal guardian of ____,

give my permission for him/her to receive chiropractic care. *signed*____ *date* ________________