Gelardi Chiropractic

Confidential Case History

Date _____

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

Mobile Phone _____ Texting? Yes / No Home Address _____

Which do you prefer for appointment reminders? Text / Email City/St _____ Zip _____

Mobile Service Provider (ie: Verizon) _____ Email _____

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: _____

_____

_____ Is care related to an accident? **Yes** **No** *(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 interfering with Work?_____ Sleep?_____Routine?_____Other?_____

Other Doctors seen for this condition _____

Any home remedies? _____

Please Circle where you are: ("0" = good) 0 1 2 3 4 5 6 7 8 9 10 ("10" = Worst)

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

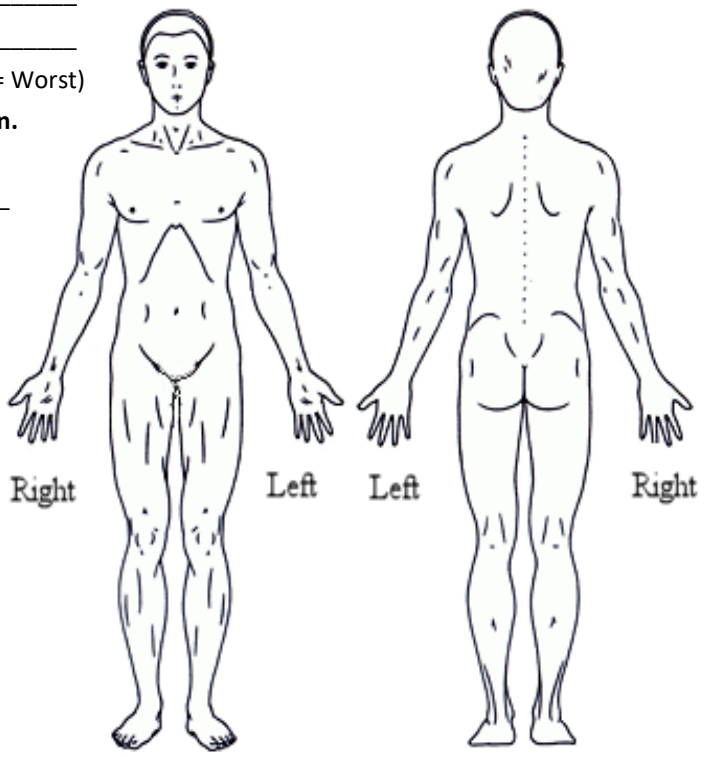
Pains are: ☐ Sharp ☐ Dull/Ache ☐ Constant ☐ Intermittent ☐ Other

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

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

(1) Numbness (2) Dull Ache (3) Burning (4) Sharp/Stabbing

(5) Tingling (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): ☐ cigarettes ☐ city water

☐ sodas ☐ artificial sweeteners ☐ alcohol ☐ fast food ☐ _____

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	Please mark any conditions you have had now or in the past.	Current/ Past
1 Allergies/ Sinus Problems	C P		33 Emotional/Mental Stress	C P
2 Asthma/ Difficulty Breathing	C P		34 Depression / Anxiety / _____	C P
3 Arthritis/ Rheumatoid A	C P		35 Alcohol/ Drug Abuse	C P
4 Chronic Fatigue/ Lupus / Fatigue	C P		36 Did/ do you smoke?	C P
5 Fibromyalgia/ Anemia	C P		37 Sleep Problems	C P
6 Cancer/ Chemotherapy	C P		38 Eye Problems	C P
7 HIV+/ AIDS	C P		39 Hearing Problems/Loss of Balance	C P
8 Other Immune Weakness	C P		40 Ringing in Ears	C P
9 Rheumatic Fever / Frequent Fever	C P		41 Dental Problems / Braces	C P
10 Pneumonia/ Bronchitis	C P		42 Physical Stress?	C P
11 Menstrual/ Fertility Problems	C P		43 Neck Pain/Stiffness (chronic/acute)	C P
12 **PREGNANT** / Menopause	C P		44 Low Back Pain (chronic/acute)	C P
13 Thyroid _____	C P		45 Mid Back Pain (chronic/acute)	C P
14 High/ __ Low … Blood Pressure	C P		46 Shoulder Pain	C P
15 High Cholesterol	C P		47 Numbness/Pain in Legs/ Feet	C P
16 Cold Hands/Feet / Leg Cramps	C P		48 Numbness/Pain in Arms/Hands	C P
17 Diabetes / Hypoglycemia	C P		49 Joint Swelling	C P
18 Fainting/ Dizziness	C P		50 Jaw/TMJ Problems	C P
19 Seizures/ Epilepsy	C P		51 Loss of Memory / Loss of Hair	C P
20 Heart Problems/Heart Attack	C P		52 Weight Loss/Loss of Smell or Taste	C P
21 Severe/Frequent Headaches	C P		**Regarding <u>YOUR</u> Birth and Childhood:**	
22 Stroke (TIA)	C P		53 Long/difficult delivery	P
23 Kidney Problems/ Painful Urination	C P		54 Forceps or extraction used	P
24 Reflux/irritable bowel/ulcer	C P		55 C-Section	P
25 Upset Stomach / Heartburn	C P		56 Breach	P
26 Constipation / Diarrhea	C P		57 Hospital (vs home) birth	P
27 Osteoporosis	C P		58 Mother given drugs during delivery	P
28 Tuberculosis	C P		59 Labor induced	P
29 Emphysema/ Glaucoma	C P		60 Bottle fed (versus breastfed)	C P
30 Artificial Bones/ Joints	C P		61 Ear infections/ Colic	C P
31 Hepatitis _____ (B or C)	C P		62 Attention Deficit	C P
32 **CURRENTLY CONTAGIOUS**	**C P**		63 **OTHER:** _____	C P

Please list all current <u>MEDICATIONS</u>.	Date started this or similar drug	Med is for what condition? Do you have any side effects?	Daily or PRN (as needed)	List **<u>SURGERIES</u>** & HOSPITALIZATIONS and year of.

Any significant **past medications** not listed above?_____

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* _____