Ireland Chiropractic Clinic

Case History

Patient Information:

Name:_____ Date: _____

Social Security #: _____ Male ___ Female___ Date of Birth:_____

Address: _____City: _____ State: _____

Email Address:_____ Zip:_____

Home Phone: (___) _____ Cell Phone: (___) _____

Occupation: _____Employer: _____

Marital Status: S M D W Spouse's name: _____

Number of Children and Ages: _____

Have you ever received Chiropractic care? _____

Whom may we thank for referring you to our office? _____

Birth to Age 5: (Please circle the ones that apply)

1.Pregnancy:

Did your mother-	Smoke or Drink alcohol	Have a proper diet
	Exercise through pregnancy	Have any falls
	Have any accidents/injuries	Physical or mental abuse

2.Birth Process:

Long Delivery	Difficult delivery	Forceps
Caesarean (C-section)	Breach/cephalic	Home birth
Hospital birth	Drugs during delivery	Induced labor

3. Growth and development

Rolled out of bed	Headbanger/rocker	Breast fed
Childhood sicknesses	Accidents	Surgeries
Drugs	Fall while learning how to walk	Picked on by siblings
Child Abuse	Pulled ear/chin	Chair pulled out
Fall down stairs	Yanked by arm	

Traumas/others: _____

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Age 5 to Present: (Please circle the ones that apply)

Did/do smoke	Did/do drink alcohol	Eat healthy foods
Teeth Problems	Ear problems	Hearing problems
Exercise Regularly	Sleeping irregularly	Occupational stress
Physical stress	Mental stress	Hobbies/Sports injuries

Accidents: _____

Surgeries/organs replaced or removed: _____

Medications: _____

Any side effects from medication or surgery: _____

Other traumas: _____

Family History: (Please mark "F" for father's side, "M" for mother's side or "B" for both)

Heart Disease Arthritis Cancer Diabetes
Other: _____

Present Health: (Please circle if you have ever experienced the following)

Headaches	Face flushed	Lights bother eyes
Neck pain	Neck Stiffness	Loss of memory
Sleeping problems	Pins &Needles in legs	Ears ring
Back pain	Pins & Needles in arms	Fever
Nervousness	Numbness in fingers	Fainting
Tension	Numbness in toes	Loss of smell
Irritability	Shortness of breath	Loss of taste
Chest pain	Fatigue	Diarrhea
Dizziness	Depression	Feet cold
Hands cold	Stomach upset	Constipation
Cold Sweats	Loss of balance	Buzzing in ears

Present Complaint: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation/

Patient Signature: _____ Date: _____
Doctor Signature: _____ Date: _____