

CASE HISTORY

Full Name: _____ Preferred Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Cellular: _____ Work: _____

Age: _____ Birthdate: (M)____/(D)____/(Y)_____ Marital Status: _____

Primary Email: _____ Spouse Name: _____

of Children: _____ and their ages: _____

Health Card Number: _____ Referred by: _____

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, especially to your nerve system, that have resulted in poor health. Following your exam, Dr. Benda will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

LOSS OF WHOLE BODY HEALTH (BIRTH TO PRESENT)

From birth, certain stresses in your life start to produce layers of damage to your spine and nervous system. Eventually you may have begun to experience symptoms and random bouts of sickness.

Birth Process / Growth and Development

Was your delivery difficult? YES NO Forceps Cesarean Breech

Were you breast fed? YES NO Childhood sickness? Please list _____

Ear infections? YES NO Were you given antibiotics? YES NO

Were you yanked/pulled by the arms YES NO Have you fallen down the stairs? YES NO

Patient Comment if Answer is Yes Chiropractor's Comments

Yes No (age 5 to present)

- | | | |
|--|-------|-------|
| <input type="radio"/> <input type="radio"/> Were you taught proper body movement and care? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Did / do you smoke? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Did / do you drink alcohol? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Diet (do you eat healthy foods?) | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Have you been in accidents / had bone fractures? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Have you had surgery; organs removed / replaced? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Drugs? (Prescriptive or non-prescriptive) | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Teeth problems? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Eye problems? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Hearing problems? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Exercise regularly? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Sleeping habits (nightmares? Insomnia?) | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Did / do you have occupational stress? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Physical stress? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Mental Stress? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Hobbies / sports injuries? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Other traumas or problems? | _____ | _____ |
| <input type="radio"/> <input type="radio"/> Family history (Diabetes, Cancer, Heart Disease, Other) | _____ | _____ |
| Sleeping posture <input type="radio"/> Side <input type="radio"/> Stomach <input type="radio"/> Back | | |

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF HEALTH)

Have you had previous chiropractic care? _____ Where? _____ When? _____
Why? _____ Dr: _____ Were X-rays taken? YES NO
What is your major complaint presently: _____

How long have you had this condition? _____ Have you had a similar condition in the past? YES NO
What activities aggravate your condition? _____

What relieves your condition? _____

Are you getting pain or numbness in your: Arms Hands Head Buttock Legs Calf Foot

Is your condition getting progressively worse? YES NO It's constant It comes and goes

Pains are: Sharp Dull Burning Tightness Throbbing

Is this condition interfering with your: Work Daily Routine Sports other _____

Other Doctor(s) who treated this condition: _____

List all surgical operation and years: _____

Drugs you now take: Anti-inflammatory Pain Killers Muscle relaxers Blood Pressure

Tranquilizers Insulin Birth control pills Other _____

Age of the mattress you sleep on: _____ Comfortable Uncomfortable

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

Have you been in an automobile accident? NO Past Year 2 to 5 years Over 5 years

Describe the accident: _____

Have you had any other personal injury or accident(s)? None Past Year 2 to 5 years Over 5 years

Describe the accident: _____

Date of last physical examination: _____

Is there a possibility that you may be pregnant? YES NO

REVIEW of BODY SIGNALS

Please put a "C" beside each symptom which you **currently** have (*or experience on a recurring basis*):

Please put a "P" beside each symptom you have had in the **past**.

___ Headaches	___ Pins & needles in legs	___ Fainting	___ Neck pain
___ Pins & needles in arms	___ Loss of smell	___ Back pain	___ Loss of balance
___ Dizziness	___ ringing in ears	___ Loss of hearing	___ Nervousness
___ Numbness in fingers	___ Numbness in toes	___ Loss of taste	___ Stomach upset
___ Fatigue	___ Depression	___ Irritability	___ Tension
___ Sleeping problems	___ Stiff neck	___ Cold hands	___ Cold feet
___ Diarrhea	___ Constipation	___ Fever	___ Hot flashes
___ Cold sweats	___ Light bothers eyes	___ Problem urinating	___ Heartburn
___ Mood Swings	___ Menstrual pain	___ Breathing difficulty	___ Ulcers
___ Seizures	___ Menstrual Irregularity	___ Jaw problems	___ Sinus problems



Power On FAMILY CHIROPRACTIC

Dr. Heidi F. Benda, BAA, DC
905 West 16th Street, North Vancouver, BC, V7P 1R2
www.PowerOnChiropractic.com 604.929.7700

Date: _____

Name: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

Numbness /////
Numbness is represented by three slanted parallel lines.

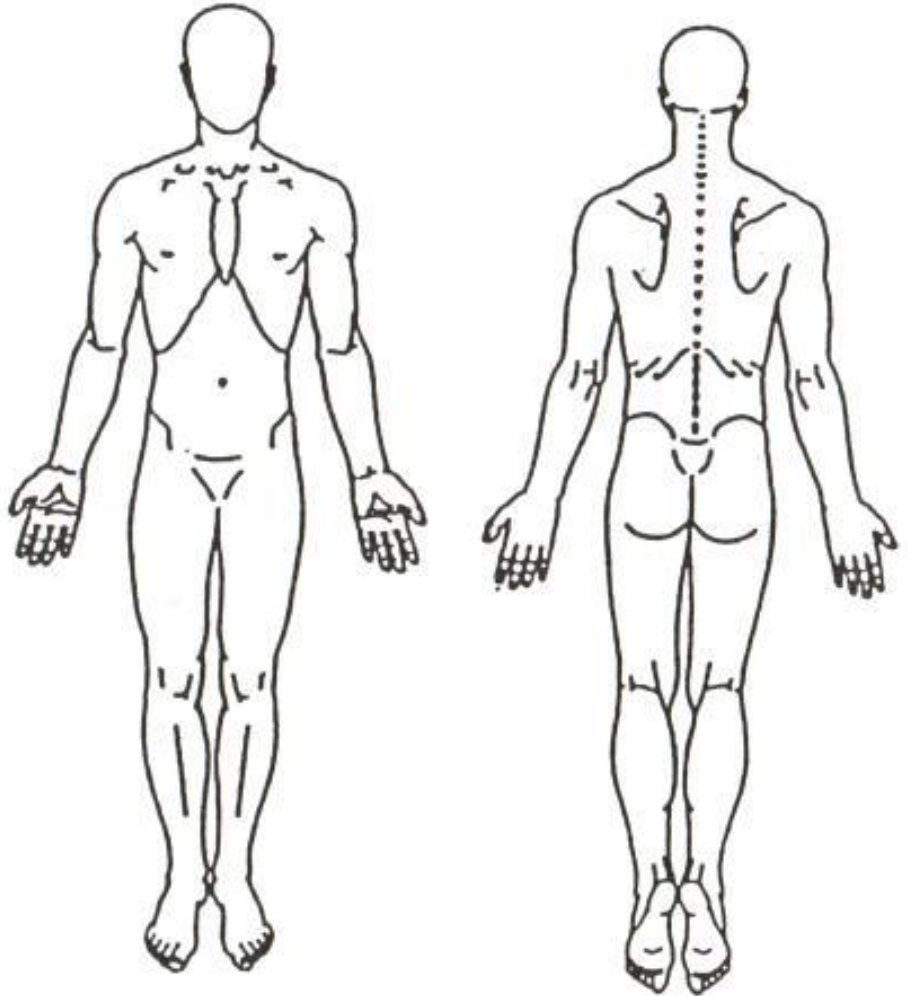
Pins & Needles ●●●●
Pins & needles is represented by four solid black dots.

Burning XXXXX
Burning is represented by five 'X' marks.

Dull & aching +++++
Dull & aching is represented by five '+' marks.

Stabbing & sharp *****
Stabbing & sharp is represented by six '*' marks.

Stiff & tight 222222
Stiff & tight is represented by two '2' marks.



Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:

- b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasions result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name (please print)

Name (please print)