Power On FAMILY CHIROPRACTIC
Dr. Heidi F. Benda, BAA, DC

CASE HISTORY

Full Name: ________________________ Preferred Name: ________________

Street Address: ____

City: ____________________ Province: ____________ Postal Code: ____________

Home phone: ______________ Cellular: ______________ Work: ______________

Gender: ______ 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

Yes	No (age 5 to present)		Patient Comment if Answer is Yes	Chiropractor's Comments
○	○	Were you taught proper body movement and care?	________	________
○	○	Did / do you smoke?	________	________
○	○	Did / do you drink alcohol?	________	________
○	○	Diet (do you eat healthy foods?)	________	________
○	○	Have you been in accidents / had bone fractures?	________	________
○	○	Have you had surgery; organs removed / replaced?	________	________
○	○	Drugs? (Prescriptive or non-prescriptive)	________	________
○	○	Teeth problems?	________	________
○	○	Eye problems?	________	________
○	○	Hearing problems?	________	________
○	○	Exercise regularly?	________	________
○	○	Sleeping habits (nightmares? Insomnia?)	________	________
○	○	Did / do you have occupational stress?	________	________
○	○	Physical stress?	________	________
○	○	Mental Stress?	________	________
○	○	Hobbies / sports injuries?	________	________
○	○	Other traumas or problems?	________	________
○	○	Family history (Diabetes, Cancer, Heart Disease, Other)	________	________

Sleeping posture ○ Side ○ Stomach ○ 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 ◯ Custom Orthotics

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

Power On
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Date: ________________________

Name: ________________________

Draw in your face

Show area(s) of pain or unusual feeling

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

Numbness /////

Pins & Needles ••••

Burning XXXXX

Dull & aching +++++

Stabbing & sharp *******

Stiff & tight 222222