

## 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 nervous system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.*

### Loss of Wellness (Birth - Age 5)

Yes	No	(Birth - Age 5)	Patient Comment (If answer is yes)	Chiropractor's Comments
<b>1. Pregnancy</b>				
<b>Did Your Mother:</b>				
<input type="checkbox"/>	<input type="checkbox"/>	Smoke or drink alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have a proper diet?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise through her pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any falls or injuries during pregnancy?	_____	_____
 <b>2. Birth Process</b>				
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
 <b>3. Growth and Development</b>				
<input type="checkbox"/>	<input type="checkbox"/>	Did you roll out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you a headbanger or rocker?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breastfed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood illnesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sitting down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? What? When?	_____	_____