JENNIFER SANSEN, D.C.
200 Bethel Road
Port Orchard, WA 98366
(360) 876-4171

CASE HISTORY

Date: _____

Name: _____ Social Security #: _____
Address: _____ City _____ State: _____ Zip: _____
Phone: ( )_____ Cell# ( )_____E-mail address _____
Age: _____ Birth Date: _____ Marital Status: S M W D How many children: _____ Ages: _____
Occupation: _____ Employer: _____
Employer Location (city) _____ Work Phone: (_____)_____
Name of Spouse: _____ Occupation of Spouse: _____
Birth Date of Spouse: _____ Social Security # of Spouse (for insurance): _____
How were you referred to our office? _____
Have you ever received chiropractic care? YES NO If yes, when? _____

Primary Complaint & Purpose of this Visit: _____

_____

How long have you had this complaint? _____

Is this the result of an injury / accident? YES NO If yes, please explain: _____

_____

Are the pains (please circle): SHARP DULL CONSTANT INTERMITTENT

Has it interfered with daily activities such as (please circle): WORK HOME EMOTION SLEEP SPORTS

OTHER (please list):_____

What makes it worse? _____

What makes it better? _____

Is it worse during certain times of the day? YES NO If yes, when? _____

Have you had this before? YES NO If yes, when? _____

Is this condition getting progressively worse? _____

List other doctors consulted for these complaints / injuries:

1. Name: _____ When consulted _____
   Treatment: _____ Results: _____
2. Name: _____ When consulted _____
   Treatment: _____ Results: _____

Any home remedies, ice, heat, etc.:_____

Other complaints:_____

I give my permission for the doctors at Kitsap Chiropractic Clinic to treat a minor child.

Parent / Guardian Signature: _____ Date: _____

Patient Name: _____Date:_____

List surgical operations & years: _____

_____

Medications:_____

Age of mattress _____ __comfortable __uncomfortable

Sleeping posture: __side __stomach __back

Are you wearing: __heel lifts __sole lifts __inner soles __arch supports

Have you been in an auto accident: __past year __past 5 years __over 5 years __never

Describe:_____

List any hobby / sports injuries: _____

Have you ever had any mental or emotional disorders? __yes __no When?_____

Have others in your family had such disorders? __yes __no When?_____

FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health. Please include conditions such as heart disease, arthritis, cancer, diabetes, etc.).

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE**
Been knocked unconscious?	☐	☐	
Been treated for a spine or nerve disorder	☐	☐	
Had a fractured bone	☐	☐	
Been hospitalized other than surgery	☐	☐	
DO YOU:	**YES**	**NO**	**DESCRIBE**
Now take vitamins or minerals	☐	☐	
Think you may need vitamins/minerals	☐	☐	

DATE OF LAST:	**0-6 months**	**6-18 mo.**	**over 18 mo.**	**never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**HEAVY**	**MOD.**	**LIGHT**	**NONE**
Alcohol	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Physical stress	☐	☐	☐	☐
Mental stress	☐	☐	☐	☐

List all conditions for which you have been treated in the last 10 years.

_____

_____

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY: (Name of relative or close friend):

Address:_____Phone:_____

Name:_____

Address: _____ Phone: _____

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PAST HEALTH HISTORY

Name: _____ Date: _____

Please indicate for each of the questions below your experience by use of the following codes:

1- Never had; 2- previously had; 3- presently have; 4- previously had & presently have.

Musculoskeletal System
___Low back problems
___Pain between shoulders
___Neck problems
___Head pain
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Weak muscles
___Walking problems
___Disc problems
___Poor posture
___Pain-shoulder/arm/hand
___Rib cage pain
___Painful tailbone
___Buttock pain
___Hip pain
___Leg pain-lower/upper

Nervous System
____Nervous
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion / Depression
___Fainting
___Convulsions
___Cold/tingling extremities
___Stress
___Tremors

General
___Fatigue
___Allergies
___Loss of sleep
___Fever
___Headaches

Gastrointestinal System
___Poor appetite
___Excessive hunger
___Excessive thirst
___Vomiting blood
___Liver trouble
___Gall bladder problems
___Weight trouble
___Bloating after meals
___Heartburn
___Black / bloody stool

Cardiovascular / Respiratory System
___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing blood
___Rapid heart beat
___Blood pressure problems
___Heart problems
___Lung problems
___Varicose veins
___Ankle swelling
___Stroke

Eye, Ear, Nose, & Throat
___Vision problems
___Ear noises
___Difficult speech
___Facial / jaw pain

Genitourinary System
___Bladder trouble
___Painful urination
___Discolored urine
___Bed wetting

Male / Female
___Prostate
___HIV positive
___Breast pain
___Breast–lumps/congested
___Periods- painful / excess
___Periods-irregular/cramps
___Hot flashes
___Menopause

Females Only
When was your last period?
_____

Are you pregnant? ___Yes
___No ___Not Sure

Childhood injuries/traumas:
_____
_____

DO NOT WRITE HERE: DOCTOR'S NOTE'S:
_____
_____
_____
_____
_____

KITSAP CHIROPRACTIC

JENNIFER H. SANSEN, D.C.
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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than Vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

_____ _____

(signature) Date