

Adolescent and Adult Health History Form

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Personal Information

Name: _____ Date: _____

Age: _____ Birth date: _____ Sex: M F

Address: _____ City: _____ Zip Code: _____

E mail address: _____ Cell Phone: _____

Home Phone: _____ Marital Status: Single Married Widowed Divorced Other _____

Emergency Contact (name): _____ Phone number: _____

Family doctor's name: _____ Address: _____

Who may we thank for referring you? _____

Why This Form is Important

Our focus is on assisting people to function optimally in order for them to become more self aware, stronger and healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional, and chemical stresses that can gradually overwhelm the body over time contributing to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

Current Health Concern

Health Concern: _____

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) 1 2 3 4 5 6 7 8 9 10

Circle or describe its character: Sharp, dull, achy, burning, tingling, throbbing, spasm, stabbing _____

When did you first notice it? _____

What happened? _____ How often does it occur? _____

What relieves it? _____ What aggravates it? _____

Does it radiate or cause problems somewhere else? _____

Any associated or related concerns? _____

Other professionals seen for this: _____

Treatment and results: _____

Recent tests done (list date beside): Bloodwork _____ Urine _____ X-Rays _____

Have you ever received chiropractic care? Yes No

Is yes, who is your previous Doctor of Chiropractic?: _____

Please describe the treatment performed: _____

The date of last visit: _____ Reason for last visit: _____

Results with that treatment: _____

Other Health Concerns

Please note all other health concerns present or in the past. Please check applicable boxes.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Lowered resistance | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Bloating | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Difficulty digestion | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Numbness and tingling |
| <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Menstrual pain and cramping |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Urinary tract infections | | |

Other: _____

For women: Are you pregnant? Yes No Unknown

If "yes" what is your estimated due date? _____ Number of ultrasounds to date: _____

Have you had prior pregnancies? Yes No Number of prior pregnancies? _____

Name of your birth care provider (OB/Midwife) _____

Provider's Contact Information _____

May we share treatment updates with your birth care provider? Please initial one:

_____ Yes, I give consent to share treatment information _____ No, I do not consent

Physical Stresses

Any significant injuries, falls or traumas (childhood & adulthood)? Yes No Unknown

If yes, please explain: _____

Any hospital visits? Yes No Have you had any surgeries, fractures, car accidents? Yes No

If yes, please explain & list dates: _____

Are you in prolonged postures? (i.e.: repetitive work, lifting, sitting, driving) Yes No Unsure

If yes, please explain: _____

Any hobbies that are physically strenuous or have repetitive movements? Yes No Unsure

If yes please explain: _____

What is your exercise level? Low Moderate Daily Heavy

Physical Stresses (continued)

What is your usual exercise routine? _____

What position do you sleep in? Back Side Stomach Hours per night? _____

Any fractured bones or dislocations? _____

Any vehicle accidents? Yes No What happened and when? _____

Chemical Stresses

Are you taking prescription or over-the-counter medications? Yes No

If yes, please explain what you are taking and why: _____

Are you currently taking supplements? Yes No

If yes, please explain what you are taking and why: _____

Do you smoke? Yes No Quit If yes, how much: _____

Do you drink alcohol? Yes No If yes, approximately how much: _____

Are you happy with your diet? Yes No Do you wish assistance with it? Yes No

Do you drink bottled water? Yes No Occasionally

Are you exposed to pollutants, strong smells, chemicals, aerosols? Yes No Occasionally

Mental/Emotional Stresses

As psychological stress has been shown to negatively affect nervous system function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme.

Life in General I feel 1 2 3 4 5 6 7 8 9 10 Work and Career I feel 1 2 3 4 5 6 7 8 9 10

Relationships I feel 1 2 3 4 5 6 7 8 9 10 Financial Stress I feel 1 2 3 4 5 6 7 8 9 10

Time Management I feel 1 2 3 4 5 6 7 8 9 10 Sports & Hobbies I feel 1 2 3 4 5 6 7 8 9 10

Quality of Sleep I feel 1 2 3 4 5 6 7 8 9 10 Health/Well-being I feel 1 2 3 4 5 6 7 8 9 10

If you are experiencing significant or ongoing stress please explain: _____

Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

Cancer Hypertension Stroke Arthritis Kidney disease Dementia Diabetes

Other _____

Why You are Here

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check the goals which apply to you so we can accommodate your wishes.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Improved Function | <input type="checkbox"/> Pain Reduction | <input type="checkbox"/> Improved Quality of life | <input type="checkbox"/> Longevity |
| <input type="checkbox"/> Symptom Management | <input type="checkbox"/> Manage my Crisis | <input type="checkbox"/> Increased Energy | <input type="checkbox"/> Stress Reduction |
| <input type="checkbox"/> Healthier Immune System | <input type="checkbox"/> Keep me Moving | <input type="checkbox"/> Improved Birth Outcomes | <input type="checkbox"/> Prevention |

Other: _____

Thank you for completing this form. If you have any questions or concerns, please write them below.

Doctor's Notes:
