Staff use only-

ID: ______________
Pmt: NPB _________
PM _________
MM _________

Adult Health History Form

Name: ______________________________________ Date:____________________________
Age: ______ Birth date : mm/dd/yyyy _____________ Sex: M F
E mail address: ___________________________
Address:____
Phone: ________________________ Marital Status: ____________
Occupation: _______________________ Who may we thank for referring you?_____________
Family doctors name and address: ____

WHY THIS FORM IS IMPORTANT: Our focus is on assisting people to function optimally, to become more self aware, stronger, 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 and contribute to other health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐
Health Concern:____
____
If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) _____________
Circle or describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms)
______________________________ When did you notice it?_________________
What happened? _____________________ How often does it occur?_______________
What relieves?______________________ What aggravates?________________________
Does it radiate or cause problems somewhere else? _______________________________
Any associated or related concerns? ____
Other professionals seen for this ____
Treatment and results____
For women: Are you pregnant? Yes No Unknown
Other health concerns: Please note all other health concerns present or in the past.

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Diseases history: (please circle if applicable)
Allergies, Frequent colds, Dizziness or lightheadedness, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Heartburn, Bloating, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Headaches, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Constipation, Loose stools, Hernia, Herniated Disc, Kidney Disease, Liver disease, Fertility problems, Miscarriage, Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Pinched nerve, Numbness and tingling, Pins and needles, Parkinson's Disease, Prostate problems, Menstrual pain and cramping, Stroke, Thyroid problem Tonsillitis Ulcers Urinary tract infections, Ulcerative colitis Other: ______________________

#2 Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**
(if yes please explain) ____
Any significant injuries, falls or traumas during adulthood? **Yes No Unsure**
(if yes please explain) ____
Any hospital visits? **Yes No** Have you had any surgeries, fractures, accidents? **Yes No**
Explain and dates _______________________________
Are you in prolonged postures (ex: 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 usual exercise routine? ____
Any fractured bones or dislocations? ____
Any vehicle accidents? **Yes No** What happened and when? _____________________________

#3 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes No (**If yes, please indicate what you are taking and why) ____
Are you currently taking supplements? **Yes No**(if yes, which ones and why?) _________________

Do you smoke? **Yes No Quit** (if yes how much?) _____________________________________
Do you drink? **Yes No** (if yes roughly how much?) _____________________________________
Do you drink tap water? **Yes No Occasionally**
Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**
Do you eat organic? **Yes / No / Occasionally**
Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes / No** ____

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#4 Mental/Emotional Stresses

As psychological stress has been shown to negatively affect many systems, 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 ______ Work and Career I feel _____ Relationships I feel ________
Financial stress I feel _____ Time management I feel ____ Sports & hobbies I feel _____
Health and well-being I feel ____ Quality of sleep I feel ____
If you are experiencing significant or ongoing stress please explain ______________________
____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No** Explain _____________________________________

#5 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 ____

#6 Why are you here?

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

Improvement in function ___ Pain reduction ___ Relief ___ Improved quality of life ____
Manage my crisis___ Information on prevention ___Symptom management ____
Healthier immune system ___ Stress reduction ___ Keep me moving___ Optimum function and quality of life ___ Improved performance ____ Full body integration____ Wellness ____
Longevity _____________ Other____

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.