ADULT HEALTH HISTORY FORM

NAME | AGE | DATE OF BIRTH (YY/MM/DD) | GENDER

ADDRESS | CITY | POSTAL CODE

PHONE NUMBER (HOME/WORK/CELL) | EMAIL ADDRESS

PHYSICIAN'S NAME | CLINIC | HEALTH CARD NUMBER

OCCUPATION | EMPLOYER | MARITAL STATUS (S/M/W/D/CL)

Who may we thank for referring you? _____

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.

current height _____ft_____inches current weight_____lbs

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

IF YES, PLEASE LIST THE NAME & DOSAGE

Do you have any diseases or diagnosed health conditions we should be aware of? ❍ Yes ❍ No

IF YES, PLEASE LIST

Do you have any severe allergies or sensitivities we should be aware of? ❍ Yes ❍ No

IF YES, PLEASE LIST

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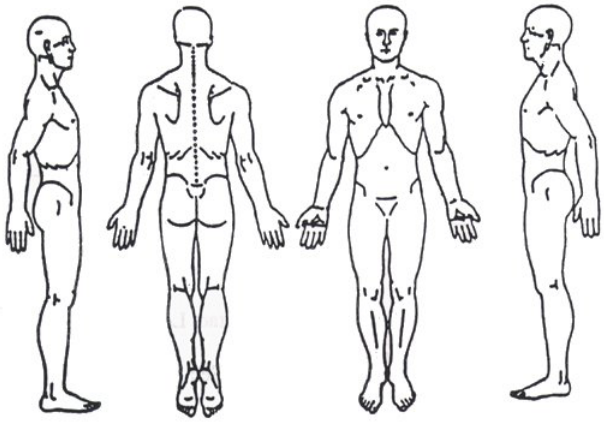
Current health concern / reason for consulting our clinic:

_____

_____

Please circle on the following diagram the affected areas of concern.



If pain is involved please rate its intensity ___/10

(RANK FROM 1-10 WITH 1 BEING MINIMAL tO 10 BEING EXTREME)

Check or describe it's character:

❍ Sharp ❍ Dull ❍ Ache ❍ Burning

❍ Tingling ❍ Throbbing ❍ Spasms

When did you first notice it? _____

How did it happen? _____

Has it happened before? ❍ Yes ❍ No When? _____

How often does it occur? _____

What makes it better? _____ What makes it worse? _____

Does it radiate or cause problems somewhere else? Where? _____

Any associated or related concerns? ❍ Yes ❍ No

_____

IF YES, PLEASE EXPLAIN

Other healthcare professionals seen for this issue? What treatment was administered and what were the results?

_____

_____

Other health concerns/reason for consulting our clinic:

_____

_____

PLEASE NOTE ALL OTHER HEALTH CONCERNS PRESENT OR IN THE PAST

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(For women) Are you pregnant? ❍ Yes ❍ No ❍ Unknown Approximate due date: _____

How many pregnancies have you had? When? _____

Diseases history: (PLEASE CHECK ALL APPLICABLE)

- ❍ Allergies
- ❍ Frequent colds
- ❍ Lowered resistance
- ❍ Dizziness/ lightheadedness
- ❍ Loss of balance
- ❍ Difficulty concentrating
- ❍ Fatigue
- ❍ Indigestion
- ❍ Heartburn
- ❍ Bloating
- ❍ Appendicitis
- ❍ 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
- ❍ Pinched nerve
- ❍ Multiple Sclerosis
- ❍ Osteoarthritis
- ❍ Rheumatoid arthritis
- ❍ Osteoporosis
- ❍ Numbness & tingling
- ❍ Pins & needles
- ❍ Parkinson's disease
- ❍ Prostate problems
- ❍ Menstrual pain & cramping
- ❍ Stroke
- ❍ Thyroid problem
- ❍ Tonsillitis
- ❍ Ulcers
- ❍ Urinary tract infections
- ❍ Ulcerative colitis

Have you been involved in any motor vehicle accidents? ❍ Yes ❍ No When? _____

What treatment / medical attention did you receive? _____

Significant injuries, surgeries, falls or traumas during adulthood? ❍ Yes ❍ No ❍ Unsure

_____

IF YES, PLEASE EXPLAIN

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving)? ❍ Yes ❍ No ❍ Unsure

_____

_____

IF YES, PLEASE EXPLAIN

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

_____

_____

IF YES, PLEASE EXPLAIN

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What kind of exercise do you participate in? Frequency?

_____

_____

Are you currently taking supplements / vitamins? ❍ Yes ❍ No

_____

IF YES, WHICH ONES & WHAT FOR?

Do you smoke or use tobacco products? ❍ Yes ❍ No ❍ Quit Do you drink alcohol? ❍ Yes ❍ No

Do you have any dietary restrictions?_____

How much water do you drink daily? _____

How much coffee, tea or pop do you drink? _____

Family Health History:
Please note any family health issues with family members such as parents, siblings, significant other or children.

❍ Cancer ❍ Hypertension ❍ Stroke ❍ Arthritis ❍ Kidney disease ❍ Dementia ❍ Diabetes
❍ Other: _____

People seek chiropractic care for a number of reasons and have certain expectations and perceptions.

Please tick the goals which apply to you so we can best accommodate your wishes.

❍ Improvement in function	❍ Healthier immune system	❍ Relief	❍ Pain reduction
❍ Stress reduction	❍ Full body integration	❍ Improved quality of life	
❍ Keep me moving	❍ Symptom management	❍ Manage my crisis	
❍ Optimum function & quality of life	❍ Information on prevention	❍ Improved performance	

Consent for examination: Please read carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

Print name: _____ Signature: _____

Date: _____

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