Eastland
Chiropractic & Lifestyle Center
Experience the Difference.

ADULT HEALTH RECORD

PERSONAL INFORMATION:

Name:	Age:	Date:
Address (Street, City):	Cell Phone: Home Phone: Work Phone:	
E-mail Address (will not share with any other entity):	Gender:	DOB:
Occupation:	Employer Name and Address:	
Best Contact Method (text, e-mail, phone):	Marital Status: Single Married Divorced Widowed Other Partner's Name: Partner's Employer:	
Number of Children, Names, and Ages:		

SOCIAL HISTORY:

How many times per week do the following activities occur? Circle the frequency.

Exercise?	Yes.	No.	1x	2x	3x	4x	5x
Tobacco use?	Yes.	No.	1x	2x	3x	4x	5x
Alcohol use?	Yes.	No.	1x	2x	3x	4x	5x
Coffee use?	Yes.	No.	1x	2x	3x	4x	5x
Supplementation?	Yes.	No.	1x	2x	3x	4x	5x
Pain relievers?	Yes.	No.	1x	2x	3x	4x	5x
Soft drinks?	Yes.	No.	1x	2x	3x	4x	5x
Water intake?	Yes.	No.	1x	2x	3x	4x	5x
Prescription drugs?	Yes.	No.	1x	2x	3x	4x	5x
Recreational drugs?	Yes.	No.	1x	2x	3x	4x	5x
Vaccinations?	Yes.	No.					
Metal filling in teeth?	Yes.	No.					

YOUR HEALTH:

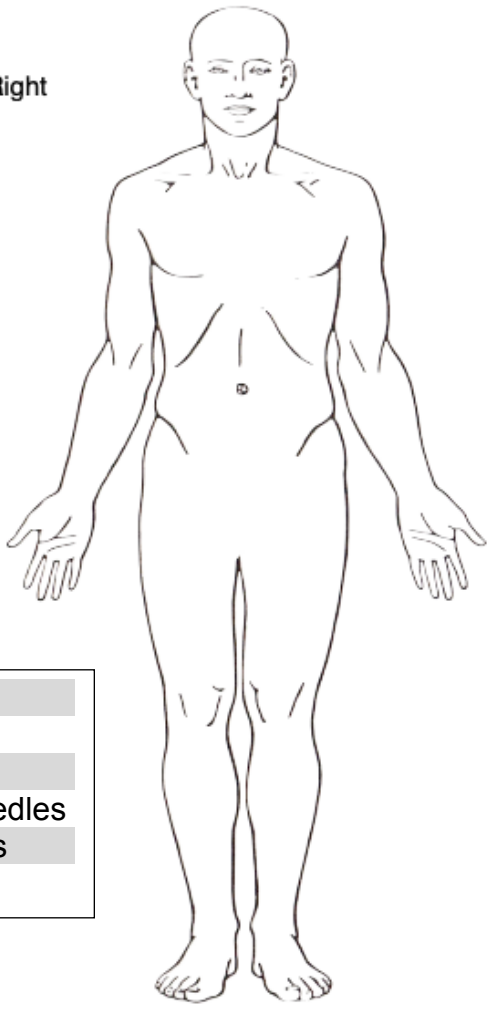
Name: _____ Date: _____

Place an “o” the segment of the line that indicates where you believe your health and wellness is at this time. Place an “x” on the line where you would ***like*** your health and wellness to be.

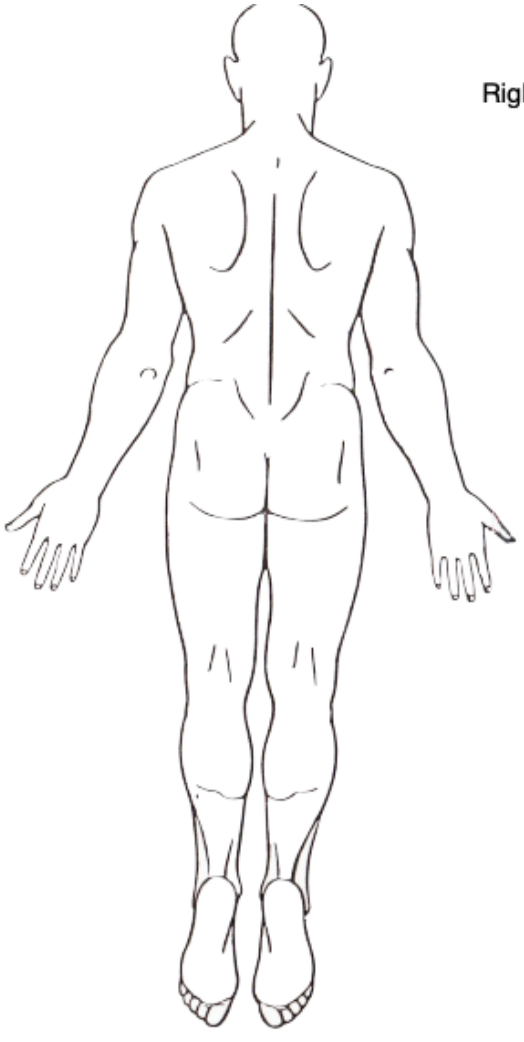
0 to 20 Very Challenged	20 to 40 Challenged	40 to 60 Transition	60 to 80 Good	80 to 100 Excellent
- Multiple medications - Poor quality of life - Potential becomes limited - Body has limited function	- Symptoms - Drug therapy - Surgery - Losing normal function	- No symptoms - Nutrition inconsistent - Exercise sporadic - Health not a high priority	- Regular exercise - Good nutrition - Wellness education - Minimal nerve interference	- 100% function - Continuous development - Active participation - Wellness lifestyle

Please mark area(s) of injury or discomfort you are currently experiencing by using table left of picture.

Right



Left Right



Key:	
///	Stabbing
XX	Burning
000	Pins & needles
==	Numbness
++	Aching

YOUR HEALTH PROFILE:

Name: _____ Date: _____

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

_____

_____

When did the problem start? _____ Since the problem started, it is… the same. getting better. getting worse.			**Doctor Notes**
What, if anything, makes it feel better?			
What makes the problem worse?			
Describe the pain:			
How often do you experience your symptoms? Constantly (76-100%) Frequently (51 to 75%) Occasionally (26 to 50%) Intermittently (0-25%)	What describes the nature of your symptoms? Sharp Radiating Dull Ache Numb Burning Tingling	Worse in the: Morning Afternoon Evening	
Does this interfere with your: work? leisure? sleep? sports? other? If other, please explain:			
Have you seen other doctors for this condition? chiropractor medical doctor other If other, please explain:			
If you have seen another medical professional, please share the following information: Name/Address:			
Date:	What was the diagnosis?		

GENERAL HISTORY:

Name: _____ Date: _____

List all prescribed and non-prescribed medications you are taking and why:

Doctor Notes

Have you had any surgeries or hospitalizations? Please include all surgeries or hospitalizations.

Have you ever had any work-related injuries?

Have you ever had any slips, falls, or auto accidents?

For female patients only:

- Are you pregnant?
  Yes. No.
- Planning on becoming pregnant?
  Yes. No.
- Are you taking birth control?
  Yes. No.
- Date of last menstrual cycle?
  _____
- Previous pregnancy complications?
  Yes. No.
- C-Section/Cesarean?
  Yes. No.

On a scale of 1 to 10 where 1 is none and 10 is extreme, circle your psychological/emotional stress levels:

Occupational: 1 2 3 4 5 6 7 8 9 10

Personal: 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10 where 1 is very poor and 10 is excellent, please circle the number associated with the following categories:

Eating habits: 1 2 3 4 5 6 7 8 9 10

Exercise: 1 2 3 4 5 6 7 8 9 10

Sleep: 1 2 3 4 5 6 7 8 9 10

General Health: 1 2 3 4 5 6 7 8 9 10

Mindset: 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____

Please mark all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches	Pins and needles in legs	Fainting	Neck pain
Loss of smell	Pins and needles in arms	Back pain	Stiff neck
Dizziness	Buzzing in ears	Ringing in ears	Nervousness
Loss of balance	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Numbness in fingers	Irritability	Tension
Sleeping problems	Depression	Cold hands	Cold feet
Diarrhea	Constipation	Fever	Hot flashes
Cold sweats	Indigestion	Urinary problem	Heartburn
Mood Swings	Tired/irritable after eating	Menstrual irregularity	Ulcers
Lights bother eyes	Recurrent lung infections	Tachycardia	Heart attacks
Thyroid condition	Recurrent colds/flus	Shortness of breath	Bed wetting
Menstrual pain			

YOUR GOALS:

At our office, we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness.

Physical Goals:	**Doctor Notes**
Nutritional/Biochemical Goals:	
Psychological Goals:	

Method of payment for first visit: Cash Check Credit Card

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____