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.					

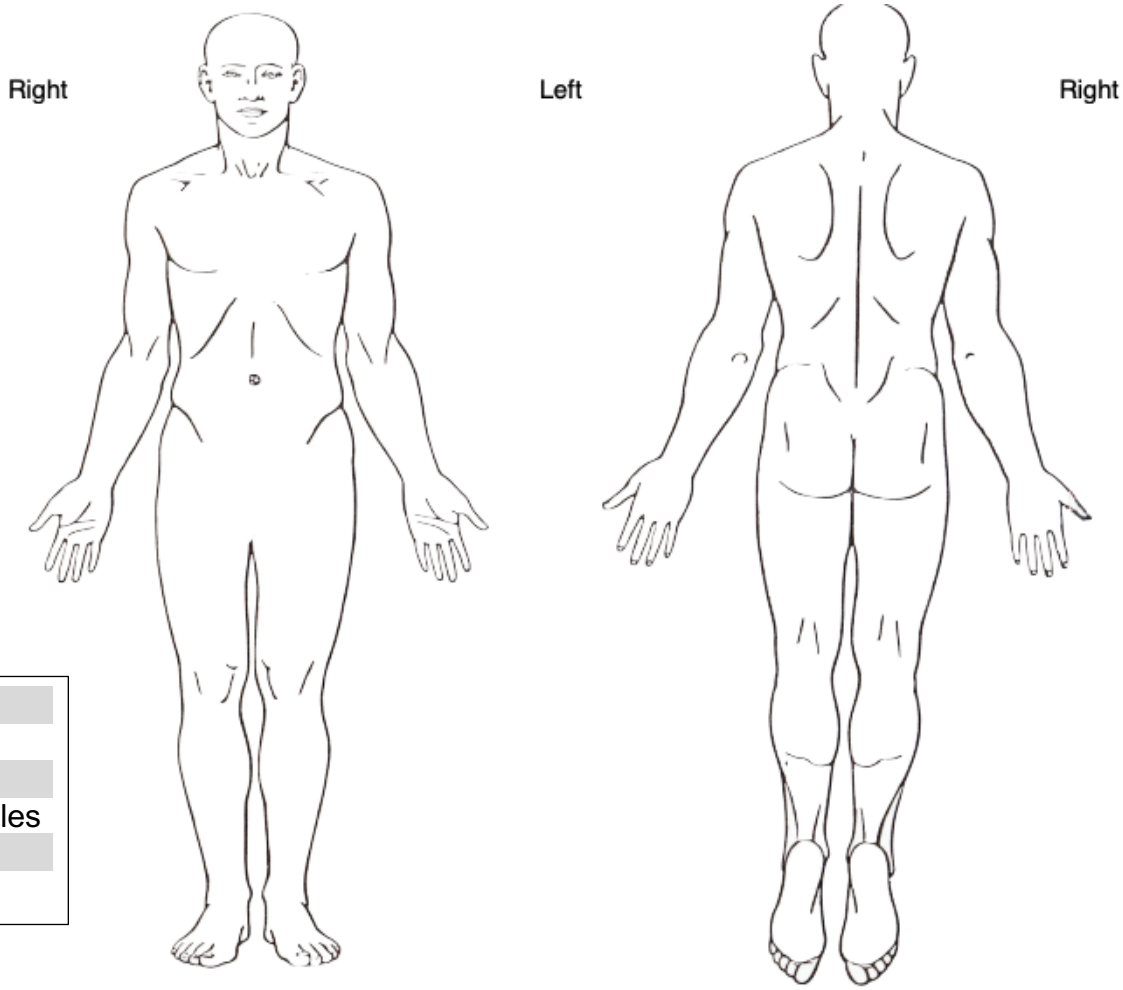
YOUR HEALTH:

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.



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.

_____

_____

<table>
<tr><td colspan="3">When did the problem start?
_____
Since the problem started, it is…
□ the same. □ getting better. □ getting worse.</td><td rowspan="9">Doctor Notes</td></tr>
<tr><td colspan="3">What, if anything, makes it feel better?</td></tr>
<tr><td colspan="3">What makes the problem worse?</td></tr>
<tr><td colspan="3">Describe the pain:</td></tr>
<tr><td>How often do you experience your symptoms?
□ Constantly (76-100%)
□ Frequently (51 to 75%)
□ Occasionally (26 to 50%)
□ Intermittently (0-25%)</td><td>What describes the nature of your symptoms?
□ Sharp
□ Radiating
□ Dull Ache
□ Numb
□ Burning
□ Tingling</td><td>Worse in the:
□ Morning
□ Afternoon
□ Evening</td></tr>
<tr><td colspan="3">Does this interfere with your:
□ work? □ leisure? □ sleep? □ sports? □ other?
If other, please explain:</td></tr>
<tr><td colspan="3">Have you seen other doctors for this condition?
□ chiropractor □ medical doctor □ other
If other, please explain:</td></tr>
<tr><td colspan="3">If you have seen another medical professional, please share the following information:
Name/Address:</td></tr>
<tr><td>Date:</td><td colspan="2">What was the diagnosis?</td></tr>
</table>

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. I authorize the doctor to share relevant health information with my physician.

Signature: _____ Date: _____