Adult and Adolescent Health History

File # _____

Name: _____ Date of Birth: _____ Age: _____ Sex: M☐ F☐

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Single: ___ Married: ____ Divorced: ____ Separated: ____ Widowed: _____ Spouse's Name: _____

Business/Employer: _____ Type of Work: _____

Business Phone: _____ Emergency Contact Name and Phone: _____

Previous Chiropractor: _____ Date of Last Visit: _____

Medical Doctor: _____ Who may we thank for referring you? _____

Why This Form Is Important: In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

Current Health Concern

Health Concern: _____

When did you notice it? _____ How often does it occur? _____

Does it radiate? Yes☐ No☐ If yes, where? _____

What relieves it? _____

What aggravates it? _____

Describe how it interferes with your life, work, or hobbies: _____

_____

Do you feel it is getting worse? Yes☐ No☐ If yes, how? _____

_____

Other Professionals Seen For Concern: _____

Treatment and Results: _____

_____

Please circle all symptoms you have experienced, even if they do not seem related to your current problem

Headaches
Pins & Needles in Arms
Dizziness
Neck Pain
Numbness in Fingers
Fatigue
Sleeping Problems
Upset Stomach
Cold Hands
Hot Flashes
Sensitive Eyes
Menstrual Pain
Pins & Needles in Legs
Loss of Smell
Buzzing in Ears
Loss of Balance
Numbness in Toes
Depression
Stiff Neck
Diarrhea
Cold Feet
Cold Sweats
Problem Urinating
Menstrual Irregularity
Fainting
Back Pain
Ringing in Ears
Nervousness
Loss of Taste
Irritability
Tension
Constipation
Heart Burn
Ulcers
Mood Swings

Please note any health issues that are present with family relations:

Sons: _____
Daughters: _____
Brothers: _____
Sisters: _____
Father: _____
Mother: _____
Grandparents: _____
_____

In this office we will perform a thorough assessment of your spine to locate areas of **Vertebral Subluxations.** Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. Vertebral subluxations compromise health by altering nervous system control and regulation of the body. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stresses

Any significant injuries or traumas during infancy that you are aware of (birth to age 5)? ☐Yes ☐No ☐Unsure
Please explain: _____
Any significant falls, traumas or injuries during childhood (age 5 to 20)? ☐Yes ☐No ☐Unsure
Please explain: _____
Any significant falls, traumas or injuries during adulthood? (over age 20)? ☐Yes ☐No ☐Unsure
Please explain: _____
Any hospital visits for concussions, possible fractures or other traumas? ☐Yes ☐No ☐Unsure
Have you had any surgeries? ☐Yes ☐No
If yes, please explain: _____
Any awkward or repetitive activities with work (i.e. assembly line work, on phone, etc.)? ☐Yes ☐No ☐Unsure
If yes, please explain: _____
Any hobbies that are physically strenuous or require repetitive activities (i.e. hockey, golf weight lifting, etc.)?
☐Yes ☐No ☐Unsure If yes, please explain: _____
What is your regular exercise routine? _____

Chemical Stresses

Are you currently taking any prescription medications? ☐Yes ☐No
If yes, which ones? _____
Do you routinely use non-prescription medications (i.e. Tylenol)? ☐Yes ☐No
If yes, which ones and how often? _____
Are you currently taking supplements? ☐Yes ☐No
If yes, which ones? _____
Do you smoke? ☐Yes ☐No How much? _____
Do you drink? ☐Yes ☐No How much alcohol? _____
Please answer the following questions regarding your diet:

Overall, how much do you eat in a day?	☐Too little	☐Moderate amount	☐Too much	☐Unsure
Daily intake of sugar?	☐Too little	☐Moderate amount	☐Too much	☐Unsure
Daily intake of caffeine?	☐Too little	☐Moderate amount	☐Too much	☐Unsure
Daily intake of fatty foods?	☐Too little	☐Moderate amount	☐Too much	☐Unsure
Daily fruits and vegetables?	☐Too little	☐Moderate amount	☐Too much	☐Unsure
Daily water intake?	☐Too little	☐Moderate amount	☐Too much	☐Unsure

Do you have any concerns about your diet and nutrition? ☐Yes ☐No
If yes, please explain: _____

Mental/Emotional Stresses

Since psychological stress has been shown to negatively affect your health potential, please answer the following questions as accurately as possible. Using the scale below, grade each of the following situations in your life.

1 - no stress **2** - a little stress **3** - moderate stress **4** - a lot of stress **5** - extreme stress

Regarding my life in general	12345	Regarding my work and career	12345
Regarding my relationships	12345	Regarding my health and well-being	12345
Regarding my finances	12345	Regarding my time management skills	12345

Please explain, in your own words, any areas in your life that you feel are causing you significant psychological stress:

_____

_____

I believe the above to be true, to the best of my recollection.

Parent's Name: _____
(For a minor under the age of 16 years)

Signature: _____ Date: _____