MountainValley
CHIROPRACTIC

Adult Health History

(Ages 13+)

Name: _____ DOB: _____ Date: _____

Spouse's Name: _____ Children's Names: _____

Occupation: _____ Employer: _____

Enrolled in Traditional Medicare? Yes No E-Mail: _____

Is today's visit due to: Illness Accident Injury Other _____

Job related? Yes No Automobile related? Yes No

Chief Complaint: _____

Circle the type of pain: Sharp Dull Burning Achy Throbbing Numb

How and when did it start? _____

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

Have you been treated for this condition before? Yes No If yes, by whom? _____

Are you currently under a healthcare provider's care for any other problems? Yes No

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Previous Chiropractic Care: Last visit? Reason? Duration of care? _____

_____

Current Medications/Supplements: _____

_____

Hospital/ER Visits/Surgeries? _____

_____

_____

Other Injuries/Accidents: _____

Rate the Following:	Poor		Average		Exceptional
General Health	O	O	O	O	O
Overall Diet	O	O	O	O	O
Exercise Routine	O	O	O	O	O
Overall Stress	O	O	O	O	O

What **Physical Stresses/Injuries** have you experienced recently? _____

_____

E**motional Stresses** (Grief, Loss, Fear, Family, Money, etc.)? _____

_____

Chemical Stresses - Do you smoke? Yes No Never Packs/day? _____ How long? _____

Do you use alcohol? Yes No Never Drinks/day? _____ per week? _____

Do you use recreational drugs? Yes No Never How often? _____

Water Intake – How much water do you drink per day? _____ ounces Type of water? _____

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Have you experienced any of the following? (circle one):

Illnesses/Frequent Colds/Ear Infections?	Y	N	Don't Know
Medication/Antibiotics/Inhaler?	Y	N	Don't Know
Falls/Injuries?	Y	N	Don't Know
Hospitalizations/Surgeries?	Y	N	Don't Know
Braces?	Y	N	Don't Know
Physical/Emotional/Sexual Trauma?	Y	N	Don't Know
Car Accidents?	Y	N	Don't Know
Difficult Birth (breech, forceps, vacuum, c-section)?	Y	N	Don't Know
Vaccine Reactions (fever, seizures, personality changes)?	Y	N	Don't Know

Have you or anyone in your immediate family experienced the following now OR in the past?

Check **O** *for You. Check* □ *for Immediate Family. Fill in type of condition on the line next to illness.*

O □ Alcoholism/Substance Abuse
O □ Allergies _____
O □ AIDS/HIV
O □ Anemia
O □ Asthma
O □ Attention Deficit Disorder
O □ Auto or Whiplash Injuries
O □ Back Pain, Spine, or Disc Problems
O □ Bedwetting
O □ Blood Pressure Problems
O □ Bursitis
O □ Cancer _____
O □ Colds or Ear Infections
O □ Constipation or Diarrhea
O □ Depression, Fatigue, or Lack of Energy
O □ Diabetes Type _____
O □ Digestive Disorders _____
O □ Dizziness or Loss of Consciousness
O □ Emphysema
O □ Epilepsy or Seizures
O □ Fibromyalgia
O □ GERD or Heartburn
O □ Gout
O □ Hand or Wrist Pain or Carpal Tunnel
O □ Heavy Metals
O □ Hip, Knee or Foot Pain, Numbness or Tingling
O □ Hormone Balance and Related Concerns
O □ Heart Disease or Heart Failure
O □ Hepatitis _____
O □ Herpes _____
O □ Inflammation or Arthritis
O □ Insomnia or Sleeping Problems
O □ Kidney Disease
O □ Learning Challenges _____
O □ Lymphatic Blockage
O □ Menopause
O □ Mental Illness _____
O □ Migraine, Stress or Tension Headaches
O □ Multiple Sclerosis
O □ Neck Pain and Stiffness
O □ Pinched Nerves
O □ PMS
O □ Poor Circulation
O □ Pregnancy and Fertility
O □ Prostate Problems
O □ Sciatica
O □ Shoulder or Arm Pain, Numbness or Tingling
O □ Spinal Curvature
O □ Stress, Anxiety or Nervousness
O □ Stroke or TIA
O □ Thyroid Disease
O □ Tinnitus (ringing in ears)
O □ Tuberculosis
O □ Ulcers
O □ Urinary Problems
O □ Weakened Immune System
O □ Work-Related Injuries
O □ Yeast/Fungus/Mold/Parasites

Patient Name: _____ Signature: _____ Date: ___/___/___