



Adult Health History

(Ages 13+)

Name: _____ DOB: _____ Date: _____

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

Occupation: _____ Employer: _____

Enrolled in Medicare/Medicare Advantage? 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

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	<input type="radio"/>				
Overall Diet	<input type="radio"/>				
Exercise Routine	<input type="radio"/>				
Overall Stress	<input type="radio"/>				

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

Emotional 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? _____



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.*

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

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