

ADULT HEALTH RECORD



TODAY'S DATE _____ NEW PATIENT _____ REACTIVE _____

ABOUT YOU

Name _____

Preferred Name _____

Birthdate _____ Sex M _____ F _____

SSN _____

Address _____

City _____ State _____ Zip _____

Ph _____ Cell _____

Email _____

How would you like to be contacted for appt. reminders?

____ Text ____ Email ____ Phone

Employer _____

Work ph _____

Student: Y N (circle one) Marital Status _____

Spouse Name _____

Spouse Ph _____

Spouse Employer _____

Emergency Contact Name _____

Ph _____

Relationship _____

How were you referred to us _____

Have you had Chiropractic care before? Y N (circle one)

If yes, Doctor/Clinic _____

ETHNICITY ____ Hispanic ____ Non-Hispanic

RACE ____ Alaska Native ____ Asian ____ Native Hawaiian

____ White/Caucasian ____ American Indian ____ Black/African American

____ Other Pacific Islander ____ Other: _____

HEALTH HABITS

Do you smoke? Y N (circle one)

If yes, how much per day _____

Do you drink alcohol? Y N (circle one)

If yes, how much per week _____

Do you drink coffee, tea or soda? Y N (circle one)

If yes, how much per day _____

Do you exercise regularly? ____ No ____ Moderate ____ Daily

Do you wear: ____ Heels ____ Arch supports

Allergies: ____ None ____ Yes (list below)

Drugs/Meds _____

Food(s) _____

Other _____

Current RX medications ____ None ____ Yes (list below)

Any past surgeries (dates): _____

Any past accidents (dates): _____

Any past injuries (dates): _____

Are you under the care of any other doctor? Y N (circle one)

Name(s): _____

DID YOU KNOW...

Chiropractors work with the nervous system? Y / N

The nervous system controls all bodily functions & systems? Y / N

Chiropractic is the largest natural healing profession in the world? Y / N

CLINIC USE ONLY (Vitals age 2+ years)

Height _____ Inches; Weight _____ lbs.; Pulse _____; Respir _____; Temp _____;

Blood pressure (left arm/right arm) _____ / _____ (sitting / standing / supine) **Staff initials** _____

FAMILY HEALTH HISTORY

	Cancer	Heart Disease	Arthritis	Diabetes
Children	___	___	___	___
Siblings	___	___	___	___
Mother	___	___	___	___
Father	___	___	___	___
Grandparents	___	___	___	___

HEALTH CONDITIONS

FEMALES: Are you pregnant Y N (circle one) Due date: _____

Date of last GY & breast exam: _____

MALES: Date of last prostate & testicular exam: _____

REASON FOR THIS VISIT

Symptoms _____

Date symptoms began _____

How did it occur? _____

___ Work related ___ Auto accident

Have you missed any work? Y N (circle one)

How much: _____ (hours/days/weeks/months)

Do you have recent X-rays of area? Y N (circle one)

If yes, facility where taken _____

HEALTH INVENTORY

Please circle the concern or condition you have now or have had in the past. Each concern relates to an area of the spine and nerve function.

- Thyroid
- Sore throat
- Stiff neck
- Radiating arm pain
- Hand/finger numbness
- Asthma
- Allergies
- High blood pressure
- Heart conditions
- Eczema
- Constipation
- Colitis
- Diarrhea
- Gas pain
- Irritable bowel
- Bladder problems
- Menstrual problems
- Low back pain
- Pain or numbness in legs
- Reproductive problems



- Headaches
- Migranes
- Dizziness
- C1 Sinus problems
- C2 Allergies
- C3 Fatigue
- C4 Head colds
- Vision problems
- Difficulty concentrating
- Hearing problems
- Anxiety
- Depression
- T2 Middle back pain
- T3 congestion
- T4 Difficulty breathing
- T5 Bronchitis
- T6 Pneumonia
- T7 Gallbladder conditions
- T8 Stomach problems
- T9 Ulcers
- T10 Gastritis
- T11 Kidney problems
- T12

PRESENT ILLNESS/INJURY

Please mark the activities with the appropriate letter:

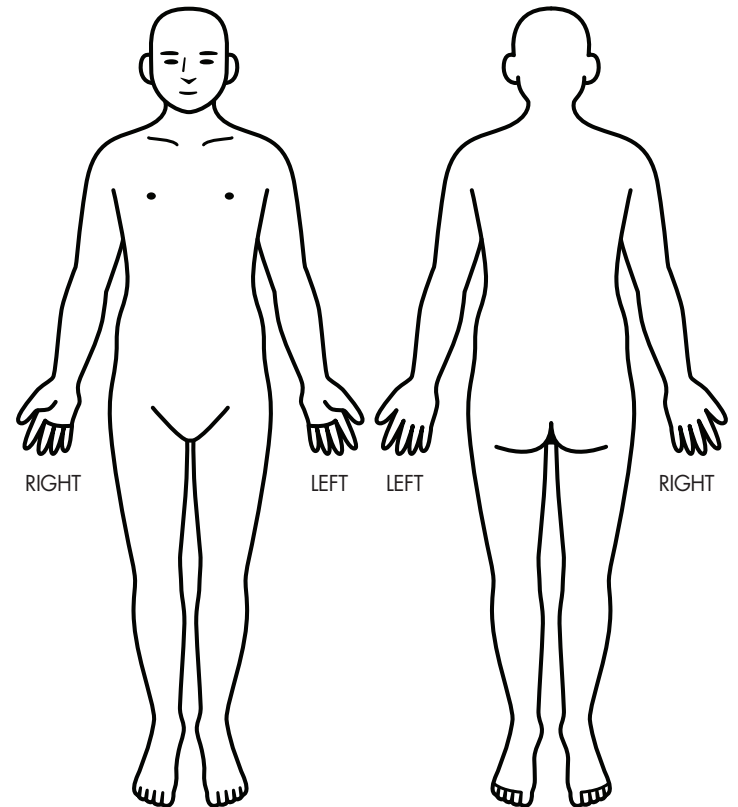
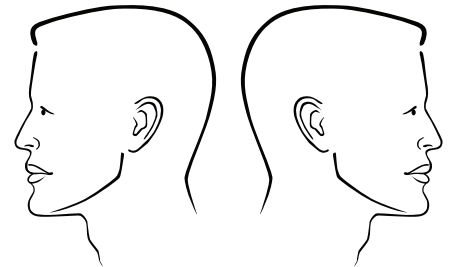
P Painful **N** Normal **L** Limited

- ___ Lying on back
- ___ Pushing/pulling
- ___ Kneeling
- ___ Lying on sides
- ___ Reaching
- ___ Walking
- ___ Lying on stomach
- ___ Dressing self
- ___ Standing
- ___ Turning over in bed
- ___ Sexual activity
- ___ Bending forward
- ___ Stooing
- ___ Getting in/out of car
- ___ Lifting
- ___ Using stairs/ladder
- ___ Sitting/Driving/Riding
- ___ Cough/sneeze/grunt
- ___ Gripping
- ___ Using a computer

PRESENT ILLNESS/INJURY

Please mark the diagram below:

- XXX BURNING PAIN
- (((ACHING PAIN
- NUMBNESS
- ::: SHARP PAIN



PAIN SCALE

Please circle your current pain level:

