ADULT HEALTH RECORD

Long Chiropractic Center

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 _____

Additional Family Member(s) _____

_____

Emergency Contact Name _____

Ph _____

Relationship _____

How were you referred to us _____

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

If yes, Doctor/Clinic _____

ETHNICITY ___ Hispanic ___ Non-Hispanic

RACE ___ Alaska Native ___ Asian ___ Native Hawaiian

___ White/Caucasian ___ Native American ___ 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)

❏ Cholesterol ❏ Thyroid ❏ Hypertension
❏ Mood Stabilizers ❏ Diabetes ❏ Pain
❏ Other _____

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

What is your main goal you'd like to achieve through care? _____

_____

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.

Headaches
Migranes
Dizziness
C1 Sinus problems
C2 Allergies
C3 Fatigue
C4 Head colds
Vision problems
Difficulty concentrating
Hearing problems
Anxiety
Depression

Thyroid
Sore throat
Stiff neck
Radiating arm pain
Hand/finger numbness
Asthma
Allergies
High blood pressure
Heart conditions
Eczema

C5
C6
C7
T1

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

Constipation
Colitis
Diarrhea
Gas pain
Irritable bowel
Bladder problems
Menstrual problems
Low back pain
Pain or numbness in legs
Reproductive problems

L1
L2
L3
L4
L5
S
A
C
R
A
L

PRESENT ILLNESS/INJURY

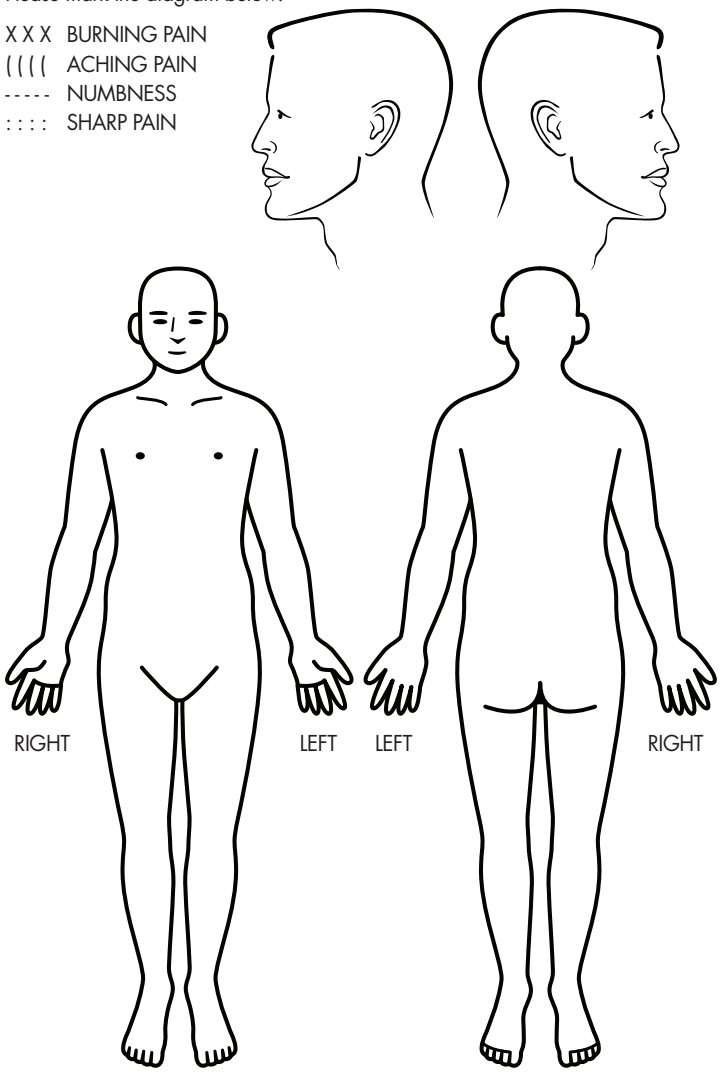
Please mark the activities with the appropriate letter:
P Painful **N** Normal **L** Limited

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

PRESENT ILLNESS/INJURY

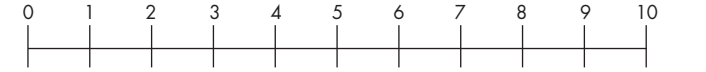
Please mark the diagram below:

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



PAIN SCALE

Please circle your current pain level:



How committed are you to your health?