Adult History Form

Thank you for taking the time to fill out this form. Your responses are important to help us to assist you in achieving the best possible health and well-being outcomes.

Date:	Last Name:	First Name:	
Title:	Preferred Name:	DOB:	Age:
Address:		Mobile:	
Email:		Other Phone:	
Occupation:		Children:	
Emergency Contact Name:		Phone:	
Who may we thank for referring you?			
Previous Chiropractic care? ☐ Yes ☐ No		Who?	
Recent x-rays? ☐ Yes ☐ No		Details:	

What is the main reason for your visit today? _____

_____

How long have you experienced this? _____

What do you think brought this on?_____

Have you experienced this before? _____

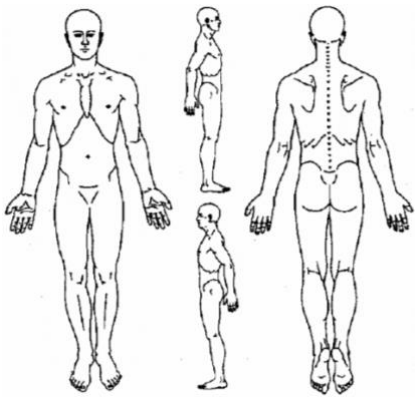
Is this limiting your life in any way? eg sleep _____

Does anything make it worse?_____

Does anything make it better?_____

Have you seen anyone else for this?_____

Is there any other relevant information?_____



Please mark the diagram to mark your areas of concern using the symbols below if relevant.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗

Right now what is the intensity of your issue?

None 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Severe

Please mark the least intense and the most intense it has been.

None 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Severe

Additional Health Information **√** ***Recent*** **X** ***Past***

○ Allergies	○ Headaches/migraines	○ Spinal curve
○ Appetite (excessive/poor)	○ Hearing problems	○ Stroke
○ Asthma	○ Heart disease/problems	○ Swelling
○ Anxiety/Depression	○ Hernia	○ Tailbone pain
○ Arthritis	○ High/low blood pressure	○ Tinnitus
○ Balance	○ Insomnia	○ Thyroid
○ Blood disorders	○ Jaw problems	○ Tonsillitis
○ Bruise easily	○ Knee problems	○ Tremors
○ Cancer	○ Low back pain	○ Ulcers
○ Circulation	○ Low immune system	○ Unexplained weight loss
○ Chronic cough	○ Lung issues	○ Visual problems
○ Chronic fatigue	○ Nausea or vomiting	○ Whiplash
○ Dental appliances	○ Neck pain	**Males**
○ Diabetes	○ Numbness	○ Fertility
○ Diarrhoea or constipation	○ Osteoporosis	○ Genitals
○ Epilepsy/seizures	○ Pain between shoulders	○ Prostate
○ Fainting	○ Pins & needles	**Females**
○ Feet problems	○ Reflux/Indigestion	○ Breasts
○ Fevers/sweats	○ Sciatica	○ Fertility
○ Fibromyalgia	○ Shoulder/elbow/hand	○ Menopause
○ Gall bladder/liver issues	○ Sinus	○ Ovaries/uterus
○ Gout	○ Skin issues	○ Menstrual problems
○ Hay fever	○ Snoring	

Is there anything else about your health history that you think we should know?

_____

Have you ever had any accidents, injuries or falls?_____

_____

Any surgeries?_____

_____

Current medications/supplements:_____

_____

Exercise/sport:_____How much water do you drink/day?_____

Do you wear orthotics?_____ How many teas/coffees per day?_____

How would you describe your diet?_____ Do you drink alcohol & if so how many/week?_____

Do you smoke & if so how many/day (if you quit how long ago)?_____

The statements and answers on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Signature:_____ Date _____