Adult and Adolescent Health History Form

Name:_____ Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F
Address:_____ City: _____ Province:_____ Postal Code: _____
Home Phone: _____ Work Phone:_____ Email Address:_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____ Consent to receive emails from us: ☐ Y ☐ N
Spouse and Children's Names (Ages): _____
Who may we thank for referring you?_____
Medical Doctor: _____ Date of Last Visit:_____
Previous Chiropractor: _____ Date of Last Visit:_____

Signature: _____ Date: _____

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

Current Health Concern

Health Concern: _____
When did you notice it? _____ How often does it occur? _____
Does it radiate? ☐ Yes ☐ No If yes, where?_____
What relieves it?_____
What aggravates it? _____
Describe how it interferes with your life, work, or hobbies: _____
_____
Do you feel it is getting worse? ☐ Yes ☐ No If yes, how? _____
_____
Other Professionals Seen For Concern:_____
Treatment and Results:_____
_____

Family Health History

Please note any health issues that are present with family relations:

Sons: _____
Daughters: _____
Brothers: _____
Sisters: _____
Father: _____
Mother: _____
Grandparents: _____

In this office we will perform a thorough assessment of your spine to locate areas of **Vertebral Subluxations**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stresses

Any significant injuries or traumas during infancy that you are aware of (birth to age 5)? ☐ Yes ☐ No ☐ Unsure
Please explain: _____
Any significant falls, traumas or injuries during childhood (age 5 to 20)? ☐ Yes ☐ No ☐ Unsure
Please explain: _____
Any significant falls, traumas or injuries during adulthood? (over age 20)? ☐ Yes ☐ No ☐ Unsure
Please explain: _____
Any hospital visits for concussions, possible fractures or other traumas? ☐ Yes ☐ No ☐ Unsure
Have you had any surgeries? ☐ Yes ☐ No
If yes, please explain: _____
Any awkward or repetitive activities with work (i.e. assembly line work, on phone, etc.)? ☐ Yes ☐ No ☐ Unsure
If yes, please explain: _____
Any hobbies that are physically strenuous or require repetitive activities (i.e. hockey, golf, weightlifting, etc.)?
☐ Yes ☐ No ☐ Unsure If yes, please explain: _____
What is your regular exercise routine? _____

Chemical Stresses

Are you currently taking any prescription medications? ☐ Yes ☐ No
If yes, which ones? _____
Do you routinely use non-prescription medications (i.e. Tylenol)? ☐ Yes ☐ No
If yes, which ones and how often? _____
Are you currently taking supplements? ☐ Yes ☐ No
If yes, which ones? _____
Do you smoke? ☐ Yes ☐ No How much? _____
Do you drink? ☐ Yes ☐ No How much? _____
Please answer the following questions regarding your diet:

Overall, how much do you eat in a day?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily intake of sugar?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily intake of caffeine?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily intake of fatty foods?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily fruits and vegetables?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily water intake?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure

Do you have any concerns about your diet and nutrition? ☐ Yes ☐ No
If yes, please explain: _____

Mental/Emotional Stresses

Since psychological stress has been shown to negatively affect nervous system function, please answer the following questions as accurately as possible. Using the scale below, grade each of the following situations in your life.

1 – no stress **2** – a little stress **3** – moderate stress **4** – a lot of stress **5** – extreme stress

Regarding my life in general	1	2	3	4	5	Regarding my work and career	1	2	3	4	5
Regarding my relationships	1	2	3	4	5	Regarding my health and well-being	1	2	3	4	5
Regarding my finances	1	2	3	4	5	Regarding my time management skills	1	2	3	4	5

Please explain, in your own words, any areas in your life that you feel are causing you significant psychological stress:

_____

_____

Authorization For Care of a Minor (Under 16 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic.

Child's Name: _____ Parent's Name: _____ Date: _____

Parent's Signature: _____ Witness: _____