Adult Health History Form

Patient Information

Name: _____

Birthdate_____/_____/_____ Age_____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Home Address:_____

City_____ State _____ Zip_____

Home Phone: _____ Cell Phone: _____

Email _____

May we add you to our email newsletter? ☐ Yes ☐ No

Occupation _____

Who is your Primary Care Physician? _____

Clinic Name_____ Date & Reason for last visit _____

May we communicate with your Primary Care Physician regarding your care if necessary?

☐ Yes ☐ No

Have you ever received Chiropractic Care? ☐ Yes ☐ No

If yes, who is your previous Doctor of Chiropractic? _____

What was the date and reason for previous visit? _____

Were you pleased with your care? ☐ Yes ☐ No

How did you find out about our office?_____

Emergency Contact

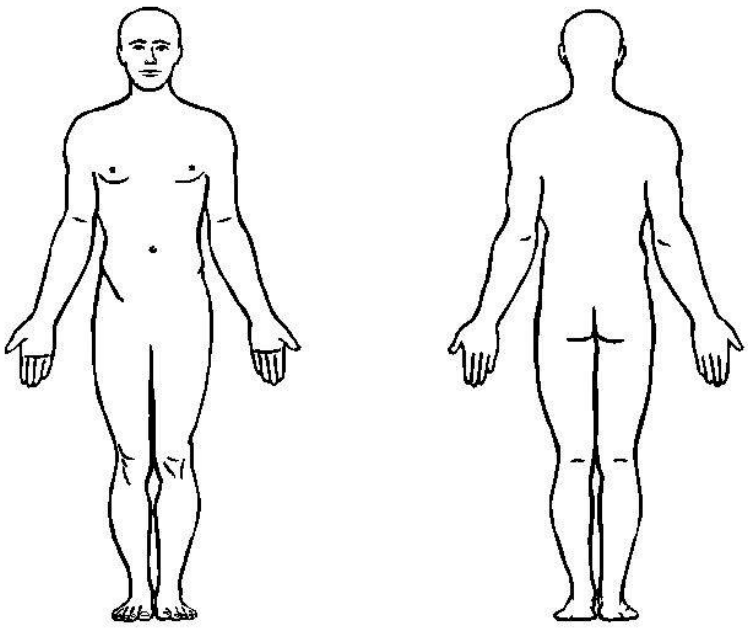
Name:_____ Relationship: _____

Phone:_____ Alternate Phone: _____

Current Health Concerns

If there are no current concerns and this assessment is to ensure optimum health, function and wellness check here ☐

Please circle on the diagram the area of your discomfort.



Please describe your present complaints_____

_____

_____

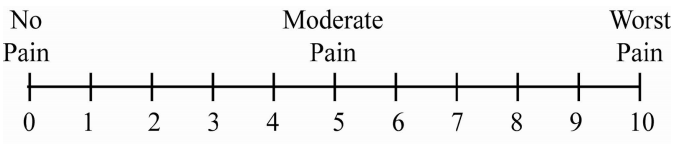
_____

_____

_____

_____

Please circle one of the numbers below to describe your current level of pain.



Is this a work related injury? ☐ Yes ☐ No
When did your present complaints first occur?_____
Does anything make it better:_____
Does anything make it worse:_____
Who has treated you for this condition (if anyone)? _____
Is this condition interfering with your
☐ Work ☐ Sleep ☐ Recreation Days missed:_____
Have you had this condition or similar conditions in the past? ☐ Yes ☐ No
If so, when?_____
What treatment did you receive_____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents:
Motorcycle accidents:
Falls or other injuries:
Spinal or neck injuries:
Broken bones:
Knocked unconscious:
Surgeries:
Health problems of parents:

Check appropriate squares (x) past or (✔) present condition:

CARDIOVASCULAR ☐ N/A
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Aortic Aneurysm
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Jaw Pain
- ☐ Irregular Heartbeat
- ☐ Swelling of Legs

GENITOURINARY ☐ N/A
- ☐ Kidney Stone
- ☐ Kidney Disease
- ☐ Lower Side Pain
- ☐ Burning Urination
- ☐ Blood in Urine
- ☐ Bed Wetting/Enuresis
- ☐ Prostate Problems

RESPIRATORY ☐ N/A
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Upper Resp. Infection
- ☐ Cold/Flu
- ☐ Pneumonia
- ☐ Cough/Wheezing
- ☐ Emphysema

EAR/NOSE/THROAT ☐ N/A
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Sinus Congestion
- ☐ Sinus Infection
- ☐ Nosebleed
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Ear Ache
- ☐ Ear Infections

GASTROINTESTINAL ☐ N/A
- ☐ Pancreatitis
- ☐ Acid Reflux
- ☐ Bowel Problems
- ☐ Constipation
- ☐ Upset Stomach
- ☐ Gas Pains
- ☐ Ulcers
- ☐ Gallbladder Problems
- ☐ Liver Problems
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Poor Appetite
- ☐ Bloody Stools
- ☐ Crohn's Disease
- ☐ Hiatal Hernia
- ☐ Frequent Urination

EYES ☐ N/A
- ☐ Double/Blurred Vision
- ☐ Glaucoma

MUSCULOSKELETAL ☐ N/A

- ☐ Chronic Hip Dislocation
- ☐ Torticollis
- ☐ Poor Posture
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis
- ☐ Broken Bones
- ☐ Joint Replacement
- ☐ Gout

ENDOCRINE ☐ N/A

- ☐ Hyperthyroid Issues
- ☐ Hypothyroid Issues
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hair Loss
- ☐ Menopausal
- ☐ Menstrual Problems
- ☐ Hot Flashes
- ☐ Endometriosis
- ☐ Polycystic Ovarian Syndrome
- ☐ Hashimoto
- ☐ Graves

ALLERGIC/IMMUNOLOGICAL

- ☐ N/A
- ☐ HIV/AIDS
- ☐ Autoimmune Disorder
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Cortisone Use
- ☐ Allergy Shots
- ☐ Chronic Allergies
- ☐ Seasonal Allergies

CONSTITUTIONAL ☐ N/A

- ☐ Pregnancy/Fertility Issues
- ☐ Speech Delays
- ☐ Learning Disabilities
- ☐ Obesity
- ☐ Weight Loss/Gain
- ☐ Energy Level Low
- ☐ Energy Level High
- ☐ Difficulty Sleeping
- ☐ Chronic Fatigue
- ☐ General Malaise
- ☐ Compulsive Behavior
- ☐ Behavior Issues
- ☐ Social Anxieties
- ☐ Depression
- ☐ Anxiety Disorder

NEUROLOGICAL ☐ N/A

- ☐ Radiating Pain
- ☐ Sciatica
- ☐ Parkinsons Disease
- ☐ Carpal Tunnel
- ☐ Balance/Coordination
- ☐ ADHD/ADD/Sensory Processing Disorder
- ☐ Autism/Spectrum Disorder
- ☐ Migraine Headaches
- ☐ Bell's Palsy
- ☐ Poor Fine/Gross Motor Skills
- ☐ Seizures
- ☐ Head Injury
- ☐ Brain Aneurysm
- ☐ Tic Disorder
- ☐ Inflammation
- ☐ Trigeminal Neuralgia
- ☐ Ear Ringing/Tinnitus
- ☐ Auditory Processing
- ☐ Toe Walking
- ☐ Sinus Headache
- ☐ Tension Headache
- ☐ Vertigo/Dizziness
- ☐ Sensory Integration
- ☐ Numbness/Tingling

The undersigned hereby consent to the treatment by Dr. Jessica Mitchell, D.C., of the below-named patient, including chiropractic care, modalities, appliances, and/or procedures, prescribed, or necessarily related to prescriptions, by patients Doctor of Chiropractic. By signing below, I acknowledge the information provided on this form to be complete and accurate, to the best of my knowledge.

Patient's Name (print)_____

Patient's Signature_____ Date_____