

Adult and Adolescent Health History Form

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ Postal Code: _____ City: _____ Province: _____

Home Phone: _____ Work Phone: _____ Email Address: _____

Health Card Number: _____

Occupation: _____

Spouse and Children's Names (Ages): _____

Who may we thank for referring you? _____

Medical Doctor: _____

Previous Chiropractor: _____ Date of Last Visit: _____

Clients come to Adjust To Life for a variety of reasons. How do you hope to benefit from care in our office?

(Please check one or more responses)

- Relief Care**- Temporary relief of the pain or discomfort
- Corrective Care**- Relieve the pain and symptoms and begin to address the underlying cause of the problem
- Wellness Care**- Maintain the correction through regular preventative care and develop a wellness lifestyle

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:
