ADULT HEALTH HISTORY

Name:_____Date:_____
Address:_____City:_____
Province:_____Postal Code:_____Phone(h)_____
(w):_____cell:_____email:_____
Marital Status:_____ # of children:_____ MSP#_____
Occupation:_____Birth date:_____

How did you hear about us and the professional services we offer?_____
What brings you in today?_____
_____
If you are here because of a particular concern, please indicate how this has affected your life._____
_____
_____

Have you ever been under chiropractic care?_____If yes, by whom?_____
What type of adjustments?_____
Did you feel it was successful?_____
Why did you discontinue care?_____
Have you ever had x-rays?_____Explain:_____
_____

Have you now or in the past participated in other forms of bodywork or alternative health care?_____
Please comment:_____

Physical history

Please list all injuries you are aware of: (ie slips, falls, car accidents etc…)_____
_____
_____
When was the most significant injury?_____
What happened?_____
_____
Have you ever broken a bone?_____Which one/s?_____
Have you ever been hospitalized?_____What for?_____
_____
Have you ever had surgery?_____What for?_____
_____
Do you have orthotics?_____ heel lift?_____
What hobbies or sports do you participate in?_____
_____

Chemical history

Do you eat a healthy diet?_____
Do/did you consume alcohol?_____How often?_____
Do/did you smoke?_____How much?_____

Do you take caffeine?_____How much?_____
Are you taking any medications or drugs?_____Which ones and what for?_____
_____
Were you vaccinated?_____Any adverse reactions?_____
Have you ever been exposed to toxins at home or work? (exhaust, fumes, poor ventilation etc..)_____
What were you exposed to?_____
Please list any vitamins, supplements or herbs taken on a regular basis:_____
_____

Emotional history (indicate past or present)

Childhood stress:_____
School:_____
Family:_____
Relationship:_____
Stress of illness: _____
Work stress: _____
Loss of a loved one: _____
Abuse:_____
Depression:_____
Other: (please list)_____

Is there some aspect of your life that very much pleases you, brings you joy, or helps you feel better about yourself?_____

When you are stressed, how do you 'centre' or 'Re group'?_____
_____

Are there any other significant events in your life or family history that may have influenced your health?_____

Based on how you feel today, grade the following stresses in your life.

Overall physical stress: (falls, accidents, repetitive strain, postural, etc…)

No stress slight stress moderate stress extreme stress

Overall emotional stress: (loss of loved one, work, financial, etc…)

No stress slight stress moderate stress extreme stress

Overall chemical stress: (drugs, smoke, diet, pollution, etc…)

No stress slight stress moderate stress extreme stress

What would motivate you to tell others about the care you receive in this office, and encourage others to receive care?_____