HEALTH HISTORY

ADULT PATIENT

Name of Patient			Date
Gender	Male ☐	Female ☐	Date of Birth / / Age
Address			
Address			
Phone Numbers: Home ( ) -		Work: ( ) -	Cell: ( ) -
Occupation			
Emergency Contact Name:			Emergency Contact Number: ( ) -
Email			

FAMILY HISTORY

Family history can often be helpful in understanding an individual's problems.

Mother's highest education level:			
Father's highest education level:			
Please check any box that applies:			
Has anyone in the family had:	***Siblings***	***Parents***	***Extended Family***
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

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UPPER CERVICAL CHIROPRACTIC

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Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐

BIRTH HISTORY

Do you have any information with regard to your birth history? _____

_____

DEVELOPMENTAL HISTORY

Do you have any information with regard to your infant health status?
For example, where you hospitalized, or had any serious health issues?

_____
_____
_____
_____

MEDICAL HISTORY

Are you regularly checked by the following:

___Medical Doctor ___Chiropractor ___Osteopath ___Naturopath ___Dentist ___Other

Do have/had braces on your teeth? ___Yes ___No

Do you have any amalgam fillings? How many? ___Yes ___No

Do you complain of any ongoing physical pains? (headaches, stomach aches, muscle/joint aches, or growing pains) ___Yes ___No

Do you suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? ___Yes ___No

Please list all of you medical and/or psychological diagnoses, past and present:

_____
_____
_____
_____

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Please list all current prescription medications:

_____

_____

_____

Are you exposed to a toxic environment (including passive smoking or industrial chemicals)? ___Yes ___No

Have you had any serious falls, physical traumas, or physical injuries? ___Yes ___No
Please list:

_____

_____

_____

Have you ever been involved in a motor vehicle accident? ___Yes ___No
Please list:

_____

_____

_____

_____

Has your hearing ever been tested? ___Yes ___No
When was your last hearing test? _____
Has your vision been tested? ___Yes ___No
When did you last visit the optometrist? _____
Do you wear glasses/contact lenses? ___Yes ___No
Have you been hospitalized? ___Yes ___No
If Yes, for what? _____

_____

Have you had any surgeries? ___Yes ___No
If Yes, what reason? _____

_____

_____

Have you had any surgeries recommended to you that have not been performed? ___Yes ___No
If Yes, for what? _____

_____

Have you had prior psychotherapy or counseling? ___Yes ___No
If Yes, for what issue? _____

_____

_____

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BEHAVIOR/MENTAL HEALTH

On a scale of 1 to 10, describe your stress level (circle one)

Personal	1	2	3	4	5	6	7	8	9	10
Occupational	1	2	3	4	5	6	7	8	9	10

Describe any sports or activities you are involved in.

_____

_____

Indicate the number of hours a week of "screen time" you use:

Computer _____ Smart Device (phone, iPad, etc.) _____

Computer games (DS, etc.) _____ Television _____

Describe your family relationships; with parents and siblings.

_____

_____

Do you have many friends? _____

Do you excel at, or struggle to build relationships with your peers? ___Excel ___Struggle ___Neither

If you struggle, why do you think that is?

_____

_____

What problems do you have with peers, if any?

___None ___Bragging to peers ___Being teased

___Being physically attacked ___Rejected by peers ___Overly physically affectionate

___Being bullied ___Jealous of peers

Do you have self esteem issues? ___Yes ___No

Do you feel that you exhibit any of the following symptoms more often than is typical? (Please check any that apply)

___Often touchy/easily annoyed ___Often bullies/threatens ___Often irritable

___Often defies rules ___Initiates physical fights ___Changes in appetite

___Often angry/resentful ___Ever been arrested ___Diminished interest

___Often argues with adults ___Physically cruel to others ___Sleep problems

___Often looses temper ___Physically cruel to animals ___Restlessness or slowed down

___Blames others for mistakes ___Motor or vocal tics ___Fatigues/low energy

___Deliberately annoys ___Destroys property ___Feels worthless

___Often spiteful/vindictive ___Deliberately sets fires ___Becomes tearful easily

___Refuses to go to work ___Lies often ___Often sad

___Repeated nightmares ___Steals ___Indecisive/can't think

___Unusual fears ___Has run away ___Thinks about death

___Panic attacks ___Extreme mood swings ___Talks about suicide

HEALTH HISTORY

ADULT PATIENT

___Self-conscious/clings
___Excessive need for reassurance
___Self-injurious behavior
___Worry of future events
___Repeats certain actions
___Somatic complaints (headache/stomach)
___Difficulty maintaining friendships
___Does not show emotions
___Overreacts to touch/noise
___Strange or bizarre ideas
___Used drugs in the past
___Poor social interactions
___Gets upset by changes in routine
___Hurts self
___Currently uses drugs
___Currently drinks beer or alcohol
___Used beer or alcohol in the past
___Can't stop thinking about things
___Excessive preoccupation with objects or ideas

Please place a check mark in the column which best describes you:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in work or other activities				
Often has difficulty sustaining attention in tasks or activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on special instructions and fails to finish tasks, (not due to oppositional behavioral failure to understand directions)				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in situations in which remaining seated is expected				
Often moves excessively in situations where it is inappropriate (may be limited to subjective feelings or restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversation or activities)				

Childhood conditions had, please check:

___Measles ___Mumps ___Chicken Pox ___Whooping cough
___Scarlet Fever ___Diphtheria ___Rheumatic fever ___Typhoid fever
___Ear Infections ___Tubes in ears ___Chronic illness

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

O	F	C	General
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fevers
			Headaches
			Loss of sleep
			Nervousness
			Depression
			Neuralgia
			Numbness
			Sweats
			Loss of weight
			Tremors
O	**F**	**C**	**Muscle & Joint**
			Arthritis
			Bursitis
			Foot trouble
			Hernia
			Low back pain
			Neck pain
			Neck stiffness
			Pain between shoulders
O	**F**	**C**	**Respiratory**
			Chest pain
			Chronic cough
			Difficulty breathing
			Spitting blood
			Throat phlegm
			Wheezing
O	**F**	**C**	**Eyes, Ears, Nose & Throat**
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Asthma
			Ear aches
			Ear discharges
			Ear noises
			Sinus infections

O	F	C	Eyes, Ears, Nose & Throat
			Tonsillitis
			Eye pain
			Failing vision
			Far sighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Near sighted
			Nosebleeds
O	**F**	**C**	**Cardio-Vascular**
			Rapid heart beat
			Slow heart beat
			Swelling of ankles
			Hardening of arteries
			High blood pressure
			Pain over heart
			Poor circulation
O	**F**	**C**	**Gastro Intestinal**
			Excessive hunger
			Burping or gas
			Liver trouble
			Colitis
			Colon trouble
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Stomach pain
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Poor appetite
			Nausea
			Vomiting
			Vomit blood
O	**F**	**C**	**Skin**
			Boils
			Bruise easily
			Dryness
			Hives or allergy

O	F	C	Skin
			Itching
			Skin rash
			Varicose veins
O	**F**	**C**	**Genito-Urinary**
			Bed wetting
			Blood in urine
			Frequent urination
			Loss control urine
			Kidney infection
			Painful urination
			Prostate trouble
			Pus in urine
			Smell of urine
O	**F**	**C**	**Pain or Numbness**
			Shoulders
			Arms
			Hips
			Legs
			Knees
			Ankles
			Feet
			Painful tail bone
			Sciatica
			Swollen joints
O	**F**	**C**	**For Women Only**
			Cramps
			Heavy flow
			Light flow
			Irregular cycle
			Painful cycle
			Discharge
			Sore breasts

Menopausal: ___Yes ___No
Last Menstruation Date: _____

Pregnant: ___Yes ___No
Due Date: _____

Do you consume alcohol? ___Yes ___No

Exercise Indoor Activities:

_____

Exercise outdoor Activities:

_____

Approximate sleep hours per night (check one):
___4-6 ___6-8 ___8-10 ___12+

Rate your sleep hours per night (check one):
__Poor __Fair __Medium __Good __Excellent

Do you wake rested? ___Yes ___No

Rate your appetite:
__Poor __Fair __Medium __Good __Excellent

Rate your diet:
__Poor __Fair __Medium __Good __Excellent

Do you eat regularly: __Breakfast ___Lunch ___Dinner

Do you eat per day:
___1 meal ___2 meals ___3 meals ___4 meals ___over 4 meals

Do you take vitamins and minerals? ___Yes ___No
If yes, please list:

_____

Do you take any recreational drugs? ___Yes ___No
If so, what?

_____

Have you ever been knocked unconscious: ___Yes ___No ___Don't know
If so, for how long?

_____

HEALTH HISTORY

ADULT PATIENT

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific question do you have that you hope an evaluation will answer?

Signature_____ Date: _____/_____/_____

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