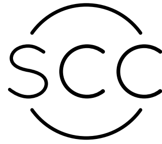

CHIROPRACTIC &
VITALITY STUDIO

ADULT HEALTH HISTORY FORM

Today's Date: ____/____/____

Name: ____

What do you prefer to be called? ____

Mailing (Street) Address: ____

City: ______________________ State: ____________ Zip Code: ______________________

Email address: ____

Home Phone ______________________ Mobile Phone: ______________________

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Birth Date: ____/______/________ Age: _____ Spouse's Name: ______________________

Names and Ages of Children:____

____

How did you learn about our office? ____

Previous chiropractic care? Yes_____ No_____ Approximate last visit date: ______________________

Hobbies: ____

____

Employer/Business: ______________________ Occupation: ______________________

Recent work related injury? Yes _____ No _____ Recent Auto Accident? Yes _____ No _____

Do you have Health Insurance? Yes _____ No _____ Medicare? Yes _____ No _____

Please check reasons for pursuing chiropractic care:

____ I'm continuing ongoing care from another chiropractor.

____ I'm Interested in wellness and natural health care.

____ I'm concerned about my health and I'm looking for answers.

____ I have a specific condition that concerns me.
Explain condition or symptom: ____

____ I want to improve my immune function.

____ I have no idea why I'm here. Please take the time to explain to me what you do.

Please check any of the following body signals/conditions you have experienced within the past year:

Dizziness or Fainting____ Headache____ Poor Posture____ Arthritis____ Asthma __ Short Leg/Orthotics____

Ear Infection____ Intestinal Problems____ Frequent Colds____ Sinus Problems____ High Blood Pressure____

Bladder Problems____ Lyme Disease____ Scoliosis____ PMS____ Menopausal Symptoms____ Infertility____

Thyroid disease____ Cancer____ Diabetes____ Alcoholism____ Stroke____ Multiple Sclerosis____ Ulcers____

Other: ____

Medical History

List high impact or contact type sports has you have been involved in over the years? (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts)?

____

____

Have you been seen on an emergency basis?

No____ Yes____ List:____

Prior surgery? No____ Yes____ List: ____

How much time do you spend using electronics (laptop, iPad, video games, cell phone)?

_________ hours per day (approximately)

List prescription or over-the-counter medications you are currently taking:

____

Known allergies: ____

____

(CONTINUED)

The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation). Which of these stresses do you recognize? Please circle when you experienced these stresses may have happened:

Physical/Emotional/Chemical Stress	Child	Teen	Adult	Comments
Birth Trauma	C			
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Sitting on a Wallet		T	A	
Sleeping on Stomach		T	A	
Extensive Computer Work		T	A	
Carrying Heavy Purse/Bookbag/Child		T	A	Amount: ________________
Repetitive Lifting/Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/Standing	C	T	A	
Family/Relationship Stress	C	T	A	
Career Stress			A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/Second Hand Smoke	C	T	A	
Poor Diet/Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount: ________________
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over-The-Counter Drugs (ex. Tylenol, Motrin)	C	T	A	

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

X ____ ______/______/__________

(Signature) (Date)