632 Maine Street
Quincy, IL 62301
217-779-6504

Adult Health History Form

Name:_____ Date:_____

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

Email address:_____

Home address:_____

Phone: (H)_____ (W)_____ (C)_____

Occupation:_____ Who may we thank for referring you?_____

Family doctor's name and address:_____

WHY THIS FORM IS IMPORTANT: Our focus is on assisting you to function optimally, become healthier and improve your ability to adapt to everyday stresses. Completion of this form provides us with an improved understanding of your physical, chemical and emotional stresses that can gradually overwhelm the body and contribute to your health concerns. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.

1. Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness, check this box) ☐

Health concern:_____

_____

If pain is involved, rank it on this scale (0=no pain, 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Circle the quality: sharp dull ache burning tingling throbbing spasm other:_____

When did you first notice it?_____

Describe what happened:_____

How often does it occur?_____ What relieves it?_____

What aggravates it?_____ Does it radiate to other parts of your body?

_____ Other professionals seen for this:_____

Is this the result of a car accident? **YES NO**

Other health concerns: Please note all other health concerns in the past (P) or current (C).

P	C		P	C		P	C	
☐	☐	ADD	☐	☐	Epilepsy	☐	☐	Migraines
☐	☐	Allergies	☐	☐	Fatigue	☐	☐	Miscarriage
☐	☐	Asthma	☐	☐	Fertility issues	☐	☐	Multiple sclerosis
☐	☐	Appendicitis	☐	☐	Frequent colds/sickness	☐	☐	Numbness/tingling
☐	☐	Autoimmunity	☐	☐	Headaches	☐	☐	Osteoarthritis
☐	☐	Bleeding disorders	☐	☐	Heartburn	☐	☐	Osteoporosis
☐	☐	Bloating	☐	☐	Hepatitis	☐	☐	Parkinson's disease
☐	☐	Bronchitis	☐	☐	Hernia	☐	☐	Pinched nerve
☐	☐	Cancer:_____	☐	☐	Herniated disc	☐	☐	Pneumonia
☐	☐	Cardiovascular disease	☐	☐	High cholesterol	☐	☐	Prostate problems
☐	☐	Cataracts	☐	☐	Hypertension	☐	☐	Psoriasis
☐	☐	Constipation	☐	☐	Hypoglycemia	☐	☐	Rheumatoid arthritis
☐	☐	Diabetes	☐	☐	Indigestion	☐	☐	Stroke
☐	☐	Diarrhea	☐	☐	Kidney disease	☐	☐	Thyroid issues
☐	☐	Difficulty concentrating	☐	☐	Lightheadedness	☐	☐	Tonsillitis
☐	☐	Digestive issues	☐	☐	Liver disease	☐	☐	Ulcerative colitis
☐	☐	Dizziness	☐	☐	Loss of balance	☐	☐	Ulcers
☐	☐	Emphysema	☐	☐	Menstrual pain/dysfunction	☐	☐	Urinarytract infection
						☐	☐	Other:_____

2. Family Health History: Please note if your spouse (SP), son (S), daughter (D), mother (M) or father (F) have or have had any of the following conditions.

Arthritis_____	Diabetes_____	Menstrual disorder_____
Asthma_____	Digestive issues_____	Migraines_____
ADD/ADHD_____	Disc problems_____	Neck pain_____
Allergies_____	Ear infections_____	Scoliosis_____
Back troubles_____	Fibromyalgia_____	Shoulder pain_____
Bed wetting_____	Headaches_____	Sinus issues_____
Cancer_____	High blood pressure_____	Stroke_____
Carpal tunnel_____	Hip pain_____	TMJ disorder_____

3. Physical Stresses:

Any significant injuries, falls or traumas during infancy or childhood? **YES NO UNSURE**
(if yes please explain)_____

Any significant injuries, falls or traumas during adulthood? **YES NO UNSURE**
(if yes please explain)_____

Any hospital visits? **YES NO** Have you had any surgeries, fractures, accidents? **YES NO**
(if yes explain and dates)_____

Any repetitive postures or movements on a daily basis (sitting, factory work, driving)? **YES NO**
(if yes please explain)_____

Any hobbies that are physically strenuous or have repetitive movements? **YES NO**
(if yes please explain)_____

Any vehicle accidents? **YES NO** Describe and dates_____
What is your usual exercise routine?_____

Give yourself a score from 0-10 on the overall physical stresses in your life (0=no physical stress, 10=maximal physical stress)_____

4. Chemical Stresses:

Do you take prescription or over-the-counter medications? **YES NO** Name of medication and reason_____
_____

Do you take supplements? **YES NO** Supplement and reason_____
_____

Do you smoke? **YES NO** Packs per day_____

Do you drink alcohol? **YES NO** Drinks per day_____

Do you eat processed food, junk food, fast food, etc. regularly? **YES NO OCASSIONALLY**

Do you drink soda, diet soda, energy drinks, or sports drinks regularly? **YES NO OCASSIONALLY**

Are you exposed to pollutants, strong smells, or chemicals regularly? **YES NO OCASSIONALLY**

Do you use natural products in your home (skin care, hair care, cleaning supplies, etc.)? **YES NO**

Give yourself a score from 0-10 on the overall chemical stresses in your life (0=no chemical stress, 10=maximal chemical stress)_____

5. Mental/Emotional Stresses:

Rank the following areas of your life from 0-10 (0=no mental/emotional stress, 10=maximal mental/emotional stress):

Relationships_____ Work/career_____ Finances_____ Hobbies_____
Time management_____ Quality of sleep_____ Health_____

Do you practice some form of prayer, breath work, meditation or other activity to reduce your stress? **YES NO** Explain_____

Give yourself a score from 0-10 on the overall mental/emotional stresses in your life (0=no mental/emotional stress, 10=maximal mental/emotional stress)_____

6. Reason you are here:

People seek chiropractic care for a number of reasons and have certain expectations. Please indicate your reason for choosing chiropractic.

☐ Wellness ☐ Improved quality of life ☐ Prevention ☐ Improved function ☐
Improved performance ☐ Drug-free healthcare ☐ Improved immune system ☐ Pain reduction ☐ Symptom reduction ☐ Other:_____

Consent for examination: Please read carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in my interests.

Name:_____ Date:_____

Signature:_____ Witness:_____

Doctor of Chiropractic:_____