

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
AGE:	
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:	
SPOUSE EMPLOYER:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
POSITION TITLE:	

HEALTH HABITS

DO YOU SMOKE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, how much per day _____
DO YOU DRINK ALCOHOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, how much per week _____
DO YOU DRINK COFFEE, TEA, OR SODA			If yes, how much per day _____
DO YOU EXERCISE REGULARLY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DO YOU WEAR:			
<input type="checkbox"/> HEEL LIFTS	<input type="checkbox"/> SOLE LIFTS	<input type="checkbox"/> INNER SOLES	<input type="checkbox"/> ARCH SUPPORTS

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO

WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

YES NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

YES NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

YES NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care:** Symptomatic relief of pain or discomfort.
- Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the appropriate type of care*

MEDICATIONS YOU TAKE

CHOLESTEROL MEDICATIONS BLOOD PRESSURE MEDICINE

STIMULANTS BLOOD THINNERS

TRANQUILIZERS PAIN KILLERS (INCLUDING ASPIRIN)

MUSCLE RELAXERS OTHER:

INSULIN OTHER:

VITAMINS & SUPPLEMENTS:

YOUR CONCERNS

INSTRUCTIONS: Please circle the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

C5
C6
C7
T1

C1 Headaches
C2 Migraines
C3 Dizziness
C3 Sinus Problems
C4 Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney

OTHER:

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

L1
L2
L3
L4
L5
S
A
C
R
A
L

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

				FOR WOMEN ONLY:
<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	DO YOU: EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	