

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 ADDRESS:	
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> CARE CREDIT	
Does daily life stress make your condition worse? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If so, how? _____	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO
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

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER

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 MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. IF YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE: <input type="checkbox"/> WELLNESS <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> JOB <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
WHEN DID THIS CONCERN BEGIN?
DOES MENTAL STRESS SEEM TO AGGREGATE YOUR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN WHICH: _____	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> VITAMIN C	<input type="checkbox"/> OTHER _____

"The doors we open and close each day decide the lives we live."

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

ARE 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 type of care for my condition.*

YOUR CONCERNS

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

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



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

T2
T3
T4
T5
T6
T7
T8
T9

L1
L2
L3
L4
L5
S
A
C

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

OTHER:

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.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY:
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING? <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	ARE YOU TAKING BIRTH CONTROL? <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	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"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	

SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

