



ADULT HISTORY FORM

Personal Information

Legal Name: _____ Date: ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

Birth Date: ____ / ____ / ____ Please circle one: Male / Female Married / Single / Widowed / Divorced

How did you hear about us? _____ Email: _____

Number of Children: ____ Names of other family members: _____

Who or what may we thank for referring you here today? _____

Have you ever been to a Chiropractor before? Y / N When was your last visit? _____

Chiropractic Services Provided

- **Consultation**-includes practice member history. This service is complimentary.
- **Examination (new patient or established patient)**-includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check, heart rate variability.
- **Chiropractic Adjustment** – The actual re-alignment of the vertebra. A specific instrument is used to make the spinal adjustment. 1 to 3 specific adjustments will be made per visit, re-aligning the vertebra.
- **X-rays** – Specific x-ray views taken of your spine to determine a misalignment/subluxations of your vertebrae. These can also be used to indicate progress after a period of care.

****All charges will be reviewed and authorized by patient before any charges are rendered.**

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.



Initials: _____ **Date:** _____

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Musculoskeletal Complaints

Area of Concern	Right/Left Both sides	Severity 1=Mild 10=Unbearable	How long have you had this?	Did this start with an injury?	Constant or comes and goes?
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Headaches					
Migraines					
Neck					
Upper Back					
Mid Back					
Low Back					
Shoulders					
Hips					
Sciatica					
Knees					
TMJ					

Other Notes:

How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

If you answered less than 10 to the previous question, what is your biggest hesitation? _____



Initials: _____ **Date:** _____

What is your main complaint: _____

1. How would you describe the pain?

- | | | | | | |
|--------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Soreness | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dull | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Spasm | <input type="checkbox"/> Burning | <input type="checkbox"/> Ache | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting |

2. Does the pain travel anywhere else? Yes No

Describe: _____

3. How often is this present?

- Constant (81 – 100%) Frequent (51 – 80%) Occasional (26 – 50%) Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____

5. What makes your complaint worse?

- Nothing Walking Standing Sitting Exercise (Moving) Lying Down Other

If other, please explain: _____

6. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who? _____

7. Please list all medications you are taking AND for what:

8. Please list any broken bones, surgeries or hospitalizations you have had and when:

9. Please list any auto accidents or injuries you have been involved in:



Initials: _____ **Date:** _____

10. Please select any of the conditions below that you (or your family) have or have had in the past with a **C** if **current issue** or a **P** if **past issue**:

	Yourself	Spouse	Children	Mother	Father
Acid Reflux					
Allergies					
Anxiety					
Arthritis					
Asthma					
Cancer					
Bladder Dysfunction					
Cardiac Condition					
Disc Problems					
Dizziness					
Ear Infections					
Epilepsy					
Fainting					
Fatigue					
Fertility					
Fibromyalgia					
High Blood Pressure					
Impotence					
Insomnia					
Irritable Bowel					
Kidney Condition					
Liver Disease					
Lupus					
Menstrual Irregularity					
Nausea					
Nervousness					
Numbness					
Sinus					
Stiffness					
Stomach Condition					
Thyroid Condition					
Ulcers					
Vertigo					