Adolescent and Adult Health History Form

www.welladjustedworld.com info@welladjustedworld.com
Well Adjusted World 715 Lake Street Suite 271 Oak Park IL 60301 (708) 848-4940

Personal Information

Name: ____ Date: __________________

Age: ___________ Birth date: __________________ Sex: ☐M ☐F

Address: __________________________________ City: __________________ Zip Code: ______________

E mail address: _____________________________________ Cell Phone: __________________________

Home Phone: ________________ Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Common-law

Emergency Contact (name): ________________________________ Phone number: __________________

Who may we thank for referring you? ____

Why This Form is Important

Our focus is on assisting people to function optimally in order for them to become more self aware, stronger and healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional, and chemical stresses that can gradually overwhelm the body over time contributing to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

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 a scale of 1 to 10 (1 is minimal, 10 is extreme) 1 2 3 4 5 6 7 8 9 10

Circle or describe its character: Sharp, dull, ache, burning, and tingling, throbbing, spasm _

When did you first notice it? ____

What happened? _______________________ How often does it occur? ____________________________

What relieves it? ________________________ What aggravates? _________________________________

Does it radiate or cause problems somewhere else? ______________________________________

Any associated or related concerns? ____

Other professionals seen for this: ____

Treatment and results: ____

Family doctor's name: ____________________________ Address: ________________________________

Recent tests done (list date beside): ☐ Bloodwork ___________ ☐_ Urine __________ ☐ XRays ____________

Other Health Concerns

Please note all other health concerns present or in the past. Please check applicable boxes.

☐ Allergies ☐ Frequent colds ☐ Lowered resistance ☐ Indigestion

☐ Loss of balance ☐ Dizziness ☐ Lightheadedness ☐Difficulty concentrating

☐ Fatigue ☐ Heartburn ☐ Bloating ☐Appendicitis

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐Pneumonia

☐ Cancer ☐ Cataracts ☐ Vision changes ☐Bleeding disorders

☐ Diabetes ☐ Hypoglycemia ☐ Epilepsy ☐Heart Disease

☐ Hypertension ☐ Headaches ☐ Migraines ☐Hepatitis

☐ High cholesterol ☐ Difficulty digestion ☐ Constipation ☐Loose stools

☐ Hernia ☐ Herniated Disc ☐ Kidney Disease ☐Liver disease

☐ Fertility problems ☐ Miscarriage ☐ Multiple Sclerosis ☐Osteoarthritis

☐ Osteoporosis ☐ Pinched nerve ☐ Rheumatoid arthritis ☐Numbness and tingling

☐ Pins and needles ☐ Prostate problems ☐ Parkinson's Disease ☐Menstrual pain and cramping

☐ Stroke ☐ Thyroid problem ☐ Tonsillitis ☐Ulcers

☐ Ulcerative colitis ☐ Urinary tract infections

Other: ____

For women: Are you pregnant? ☐Yes ☐No ☐Unknown

If "yes" what is your estimated due date? ________________

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, car accidents? ☐Yes ☐No

If yes please explain and list dates: ____

Are you in prolonged postures? (i.e.: repetitive work, lifting, sitting, driving) ☐Yes ☐No ☐Unsure

If yes please explain: ____

Any hobbies that are physically strenuous or have repetitive movements? ☐Yes ☐No ☐Unsure

If yes please explain: ____

What is your exercise level? ☐Low ☐Moderate ☐Daily ☐Heavy

What is your usual exercise routine? ____

What position do you sleep in? ☐Back ☐Side ☐Stomach

For how many hours? ____

Any fractured bones or dislocations? ____

Any vehicle accidents? ☐Yes ☐No What happened and when? ____

____

Chemical Stresses

Are you taking prescription or over-the-counter medications? ☐Yes ☐No

If yes please explain what you are taking and why: ____

____

Are you currently taking supplements? ☐Yes ☐No

If yes please explain what you are taking and why: ____

____

Do you smoke? ☐Yes ☐No ☐Quit If yes, how much: ____

Do you drink alcohol? ☐Yes ☐No If yes, approximately how much: _______________________________

Are you happy with your diet? ☐Yes ☐No Do you wish assistance with it? ☐Yes ☐No

Do you drink bottled water? ☐Yes ☐No ☐Occasionally

Are you exposed to pollutants, strong smells, chemicals, aerosols? ☐Yes ☐No ☐Occasionally

Mental/Emotional Stresses

As psychological stress has been shown to negatively affect nervous system function, please let us know how intense your stress is in each of these areas. Rank from 1 to 10, with 1 being minimal and 10 being extreme.

Life in general I feel	1 2 3 4 5 6 7 8 9 10	Work and Career I feel	1 2 3 4 5 6 7 8 9 10
Relationships I feel	1 2 3 4 5 6 7 8 9 10	Financial stress I feel	1 2 3 4 5 6 7 8 9 10
Time management I feel	1 2 3 4 5 6 7 8 9 10	Sports & hobbies I feel	1 2 3 4 5 6 7 8 9 10
Quality of sleep I feel	1 2 3 4 5 6 7 8 9 10	Health/ well-being I feel	1 2 3 4 5 6 7 8 9 10

If you are experiencing significant or ongoing stress please explain _____________________________________

____

Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

☐Cancer ☐Hypertension ☐Stroke ☐Arthritis ☐Kidney disease ☐Dementia ☐Diabetes

☐Other ____

____

Why You are Here

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check the goals which apply to you so we can accommodate your wishes.

☐Improvement in function ☐Pain reduction ☐Improved quality of life

☐Manage my crisis ☐Wellness ☐Symptom management

☐Healthier immune system ☐Stress reduction ☐Keep me moving

☐Relief ☐Improved performance ☐Longevity ☐Optimum function and quality of life

☐Full body integration ☐Information on prevention

☐Other: ____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

____

____

____

____

____

____

____

Doctor's Notes:

____

____

____

____

____

____

____

____