

Adult Health History

Welcome to Family First Chiropractic

Name _____
Address _____
City _____ Prov _____ PC _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)
Referred By _____

Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
No. of children _____
Manitoba Health registration # _____
MD's Name _____

Chiropractic History

Have you previously seen a chiropractor? Yes No Reason _____ Did they take x-rays? Yes No
If yes, when was your last visit and how long did you receive care _____

Current Health Condition *I'm here for wellness and have no complaints* *(Please skip to the next section)*

Reason for today's visit _____

Pain or problem started on _____ Why do you think the problem/pain started? _____

Pain is: Sharp Dull Constant Intermittent Pain is interfering with: Work Sleep Routine Other _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is it worse during certain times of the day? _____ Is this condition getting progressively worse? Yes No

Other Doctors seen: _____ Any home remedies? _____

Other symptoms:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Frequent colds/flu |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> IBS / Crohn's disease |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Constipation | <input type="checkbox"/> Other Conditions or diseases _____ |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Balance | |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ear | _____ |

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates: _____

Any work, sports or other injuries: _____

Any medications you are currently taking: _____

Have you had surgery? Yes No What type? _____ When? _____

Any significant family medical conditions/history: _____

Give a brief description of the physical nature of your work: _____

Rate your occupational stress (1-10, 10 being the most stressful) _____

What types of physical, emotional and chemical stressors have you experienced _____

Do you smoke? Yes No How many per day? _____ Do you drink alcohol? Yes No How many per week? _____

As a result of my chiropractic care, I would like to: *(Please check all that apply)*

- Feel better quickly Have a healthier spine Live a healthier lifestyle Have a healthier body by keeping my nervous system healthy

Signature _____

Date _____