Adolescent and Adult Health History Form

Balance Chiropractic, 209 Bayfield Street, Barrie ON L4M 3B4 (705)252-2222

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Today's Date (dd/mm/yyyy): _____

Name:_____ Sex: M F Age: _____

Birth date (dd/mm/yyyy): _____ Occupation: _____

Address: _____ City:_____ Postal Code:_____

Phone: (home)_____ (work)_____ (cell)_____ Email: _____

Marital Status:_____ Medical doctor's name and address: _____

Previous chiropractor's name and city: _____ Date of last appointment:_____

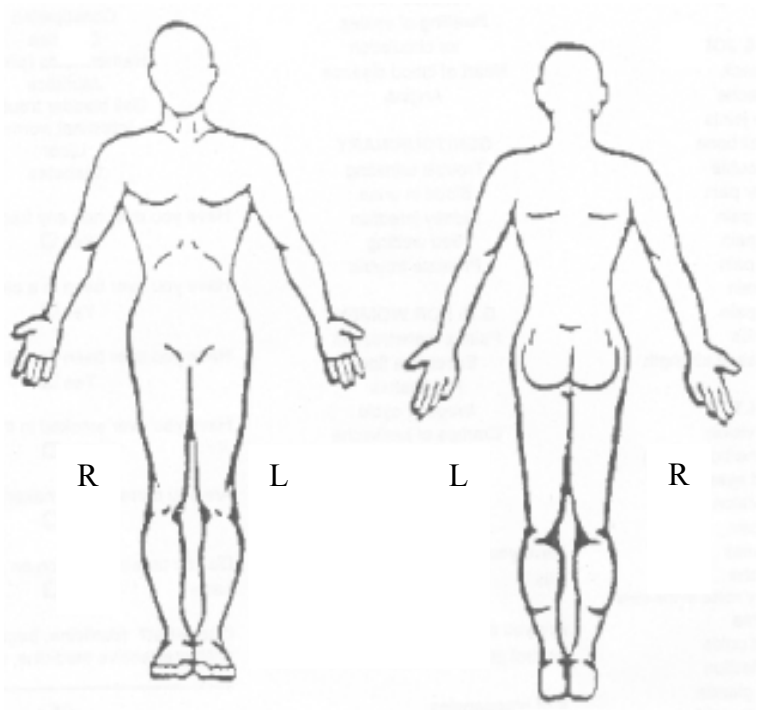
Who may we thank for referring you? / How did you hear about the office? _____

WHY THIS FORM IS IMPORTANT **In this office our focus is on assisting people to function optimally in order for them to become more self aware, stronger, 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.**

#1 Current Health Concern(s): (*If there are no current concerns and this assessment is to ensure optimum health and functioning please skip to section #2.)*

Please mark the area(s) on your body that are causing you **pain** or **unusual sensation(s)** with the appropriate symbols.

Numbness	NNNNN NNNNN NNNNN
Burning	XXXXX XXXXX XXXXX XXXXX
Dull & Aching	DDDDD DDDDD DDDDD DDDDD
Pins & Needles	•••••• •••••• •••••• ••••••
Sharp & Stabbing	SSSSSS SSSSSS SSSSSS SSSSSS
Tight & Stiff	TTTTT TTTTT TTTTT TTTTT



FRONT BACK

Location of major complaint: _____ When did it start? _____

Rank the level of discomfort (1 = minimal to 10 = extreme): _____ /10

Is it getting: worse___ better___ constant___

How often does it occur? _____ What relieves it? _____

Does it cause problems somewhere else? _____ What aggravates it? _____

Any associated or related concerns? _____ Other professionals seen for this? _____

(OVER)

#2 Physical Stresses:

List all significant **injuries**, **traumas** and **motor vehicle accidents** during childhood and adulthood:

_____

List all **hospital visits** for surgeries, possible fractures, concussions, trauma or other reasons including dates:

_____

Are you in **prolonged postures** during the day (repetitive work / lifting / sitting / driving etc.)? **Yes No Unsure**
If yes, please explain _____

What is your usual **exercise routine**? _____

#3 Chemical Stresses:

List any current prescriptions or over-the-counter **medications**: _____

List any **supplements** (vitamins / minerals / herbs etc.): _____

Do you **smoke**? **Yes No** ____/day How **long** have/did you smoke? ____ years Do you **drink**? **Yes No** ____/week

How would you rate your **diet**? **Excellent Good Poor**

#4 Mental/Emotional Stresses:

Psychological stress has been shown to negatively affect nervous system function. On a scale of 1 to 10 please rank your **overall stress level** (1 = minimal to 10 = extreme): ____ / 10

#5 General Health History:

Weight: _____ Height: _____

List any past or present **health condition(s)** or **disease(s)**: _____

Do you have a significant history or recent experiences of any the following (please **circle** all that apply):

Allergies	Sleep problems	Bladder problems	Night sweats	Loss of consciousness
Asthma	Headaches	Chest pain	Loss of weight	Weakness
Dizziness	Eye problems	Heart disease	Cancer	Stroke
Nausea / vomiting	Indigestion / heartburn	High blood pressure	HIV / AIDS	Painful menstruation
Fatigue	Ulcers	Diabetes	Arthritis	Irregular menstrual cycles
Anxiety	Constipation / diarrhea	Recurrent ear infections	Multiple Sclerosis	Infertility
Depression	Loss of smell / taste	Hearing problems	Loss of balance	Other

Have you ever had any **X-rays / CT scans / MRIs**? **Yes No** (if yes, **body part** and **year?**) _____

Do you wear custom made **orthotics**? **Yes No** Would you like information on custom made orthotics? **Yes No**

#6 Family Health History:

Please note any family health issues:

Son(s) _____ Daughter(s) _____
Brother(s) _____ Sister(s) _____
Father _____ Mother _____
Grandparents _____

#7 Chiropractic Goals:

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check (√) which statement best applies to you:

___ I have a specific problem and I require help only with this problem.

___ After my specific problem has been relieved, I am interested in strategies to help ensure it does not return.

___ After my specific problem has been resolved and I have followed advice to help ensure it does not return, I am interested in strategies to improve my general health.

___ I have no symptoms and I feel well. I am interested in strategies to help me feel and function even better.

I agree and understand that I am personally responsible for all charges relating to my care at the clinic. The clinic will provide me with the necessary paperwork upon request in order to make a claim with my health insurance plan. Furthermore, I give the doctor my consent to a complete consultation and physical examination on me.

Date: _____ Signature: _____

Date: _____ Guardian's Signature: _____
(if patient is under 18 years of age)