ADULT AND ADOLESCENT HEALTH HISTORY FORM

Wihlidal Family Chiropractic Centre 15 Matchedash St. N Orillia, ON L3V 4T4

Name:_____ Age:_____ Birth date:_____ /_____ /_____ Sex: M F
(month / day / year)

Address:_____ City:_____ Postal Code: _____

Marital Status: S M W D CL

E-mail Address:_____@_____

Primary Phone #_____ Alt Phone #_____

Occupation and description of work you do_____

Spouse and Children Names (Ages) _____

Previous Chiropractor _____ Date of last visit:_____

Medical Doctor _____

Who may we thank for referring you?_____

SIGNATURE:_____ **Date**:_____

THE PURPOSE OF THIS FORM

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form to the best of your ability and the doctor will review it with you.

#1 CURRENT HEALTH CONCERN (if there are no current health concerns and this assessment is for wellness and optimum functioning, skip to #2)

Health Concern:_____

When did you notice it?_____ How often does it occur?_____

Does it radiate? _____ Where? _____

What relieves?_____ What aggravates?_____

How does this interfere with your life, work or hobbies? _____

Do you feel it is getting worse? _____

Other professionals seen for concern_____ Treatment and Results_____

#2 FAMILY HEALTH HISTORY

Please note any health issues that are present with family relations

Sons_____ Daughters_____

Brothers_____ Sisters_____

Father_____ Mother_____

Grandparents_____

In this office we will perform a thorough assessment of your spine to locate areas of **SUBLUXATION**. **SUBLUXATIONS** are areas of dysfunction in the spine that irritate or choke off the nervous system. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. **SUBLUXATIONS** are caused by <u>physical</u>, <u>chemical</u> and <u>mental/emotional</u> stresses that overwhelm the nervous system. Please complete the opposite side of this form to the best of your ability. This will help us to determine the causes of the **SUBLUXATIONS** we may find.

(Please complete other side)

PHYSICAL STRESSES

Any significant injuries or traumas during infancy that you are aware of (birth to 5 y.o.)? **Yes No Unsure**
Please explain_____
Any significant falls, traumas or injuries during childhood (5 to 20 y.o.)? **Yes No Unsure**
Please explain _____
Any significant falls, traumas or injuries during adulthood (over 20 y.o.)? **Yes No Unsure**
Please explain _____
Any hospital visits for concussions, possible fractures or other traumas? **Yes No Unsure**
Have you had any surgeries? **Yes No** If yes, please explain_____
Any awkward or repetitive activities with work (i.e./ assembly line work, cradling phone in neck, etc.)?
Yes No Unsure If yes, please explain _____
Any hobbies that are physically strenuous or require repetitive activities (i.e./ hockey, golf, weightlifting, etc.)?
Yes No Unsure If yes, which ones? _____
What is your regular exercise routine? _____

CHEMICAL STRESSES

Are you currently taking any prescription medications? **Yes No** If yes, which ones _____
_____
Do you routinely use non-prescription medications (i.e./Tylenol)? **Yes No** If Yes, which ones and how often?
_____
Are you currently taking any supplements? **Yes No** If yes, which ones _____
Do you smoke? **Yes No** How much? _____ Do you drink? **Yes No** How much? _____
Regarding your diet, please answer the following questions:

Overall, how much to you eat in a day?	**Small amount**	**Moderate amount**	**Large amount**	**Unsure**
Daily intake of sugar?	**Small amount**	**Moderate amount**	**Large amount**	**Unsure**
Daily intake of caffeine?	**Small amount**	**Moderate amount**	**Large amount**	**Unsure**
Daily intake of fatty foods?	**Small amount**	**Moderate amount**	**Large amount**	**Unsure**
Daily intake of fruits and veggies?	**Small amount**	**Moderate amount**	**Large amount**	**Unsure**
Daily water intake?	**Small amount**	**Moderate amount**	**Large amount**	**Unsure**

Do you have any concerns about your diet and nutrition? **Yes No** Explain_____

MENTAL/EMOTIONAL STRESSES

Since psychological stress has been shown to negatively affect nervous system function, please answer the following questions as accurately as possible. Using the scale below, grade each of the following situations in your life.

1– no stress **2**–a little stress **3**-moderate stress **4**-a lot of stress **5**-extreme stress

Regarding my life in general, I feel _____
Regarding my relationships, I feel _____
Regarding my finances, I feel _____
Regarding my work and career, I feel _____
Regarding my health and well-being, I feel _____
Regarding my time management skills, I feel _____

Please explain, in your own words, any areas in your life that you feel are causing you significant psychological stress.
_____

Thank you for completing this form. If you have any further concerns, please note them in the space below.

Authorization for Care of a Minor (Under 16 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child at the Wihlidal Family Chiropractic Centre.
Child Name:_____ **Parent Name:**_____ **Date:**_____
Parent Signature:_____ **Witness:**_____