thrive
CHIROPRACTIC
EXTRAORDINARY HEALTH - EXTRAORDINARY LIFE

ADULT HEALTH QUESTIONNAIRE (Age 13+)

Today's Date _____ Acct# _____

First Name _____ Middle Initial _____ Last Name _____
What would you prefer to be called? _____ Date of Birth _____
Address _____ City _____ State _____ Zip Code _____
Home Phone ( )_____ Mobile Phone ( )_____ Work Phone ( )_____
E-mail _____
Gender: Male Female Marital Status: Single Married Separated Divorced Widowed
Spouse/Partner's Name _____
Children's Names and Ages _____
Do you have any pets? Yes No If yes, please tell us what kinds _____
Favorite hobbies or interests _____
Emergency Contact: Name _____
Relationship _____ Phone # _____
Whom may we thank for referring you to our office _____

HEALTH HISTORY

What brings you into our office? Please briefly describe your concerns, including the impact they are having on your life. **If you have no symptoms and are seeking Chiropractic Wellness Services, please skip to the next section.**

_____
_____
_____

Is this appointment related to an accident or injury? Yes No
If yes, please describe _____
_____
_____

When did your health concern(s) begin? _____

How often do you experience this/these problems?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

How are these concerns changing? Getting better No change Getting worse

Have you experienced these health concerns prior to this episode? Yes No
If yes, how long ago? _____

What describes the nature of your symptoms?
Sharp Dull Aching Numb Shooting Burning Tingling Throbbing

Indicate the average intensity of your symptoms: 0-None 1 2 3 4 5 6 7 8 9 10-Unbearable

Does this interfere with: Work Sleep Walking Hobbies Leisure Other _____

What makes the problem worse? _____
What, if anything, makes it feel better? _____

Have you ever had chiropractic care before? Yes No For this issue? Yes No
If yes, please tell us with whom _____ Phone # _____
Were you pleased with your care? Yes No

Have you seen anyone else for this problem? Yes No If yes, who? _____
What treatment did you receive? _____
Were you happy with your treatment? Yes No

POTENTIAL CAUSES OF HEALTH PROBLEMS

It has been shown that daily lifestyle stress *significantly* impacts your overall health and wellbeing. As a family wellness office we specialize in not only removing the ***cause*** of your health challenges, but we also focus on helping you **manage lifestyle stresses** that are limiting you from reaching your optimum health potential and wellness.

PHYSICAL STRESSORS

Do you exercise? Yes No If yes, please explain_____
Do/did you play sports? Yes No If yes, please explain _____
How many hours/day do you spend in front of a computer? _____ Watching TV? _____

Have you had any surgeries or hospitalizations? Yes No
If yes, please list all incidencies/procedures and approximate dates _____
_____
_____

Have you had any work related injuries? Yes No If yes, please explain _____

Slips and falls, although common, have a direct impact on your health and wellbeing. Even “minor” falls or accidents cause stress, strain and damage to the spine and can take months to heal.

If you have had any slips/falls/automobile accidents (no matter how minor), please list them here:
_____
_____
_____

CHEMICAL STRESSORS

You may not be aware that perscription medications are the third leading cause of death in the United States. We are interested in knowing what, if any, you are taking and why: _____
_____
_____

Do you take vitamins/supplements? Yes No If yes, please list _____
_____
_____

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
___	___	OTC Medications	___	___	Caffeine	___	___	Nicotine
___	___	Energy Drinks	___	___	Soda (Regular or Diet)	___	___	Sugar
___	___	Fast/Processed Food	___	___	Artificial Sweetner			
___	___	Alcohol	___	___	Recreational Drugs			

Please list any other chemical stressors you encounter on a daily basis _____
_____

EMOTIONAL/PSYCHOLOGICAL STRESS

On a scale of 0-10, with 0 = No Stress and 10 = Extreme Stress, please describe your stress levels:
Personal _____ Relationships _____ Family _____ Financial _____ Work _____

On a scale of 0-10, with O=Worst and 10= Best, please rate how well you think you're doing with the following:
Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____

HEALTH INVENTORY

MEDICAL SYMPTOMS QUESTIONNAIRE

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head:
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Eyes:
_____ Watery or Itchy Eyes
_____ Swollen, Red or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision (*not* including near or far sightedness)

Ears:
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear
_____ Ringing in Ears, Hearing Loss

Nose:
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation

Mouth & Throat:
_____ Chronic Cough
_____ Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness
_____ Swollen or Discolored Tongue
_____ Canker Sores

Skin:
_____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating

Energy/Activity:
_____ Fatigue/Sluggishness
_____ Apathy/Lethargy
_____ Hyperactivity
_____ Restlessness

Weight:
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight

Emotions:
_____ Mood Swings
_____ Anxiety/Fear/Nervousness
_____ Anger/Irritability/Aggressiveness
_____ Depression

Mind:
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Poor Physical Condition
_____ Difficulty Making Decisions
_____ Stuttering or Stammering
_____ Slurred Speech

Joints/Muscles:
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limited Movement
_____ Pains or Aches in Muscles
_____ Weakness or Fatigued Muscles

Lungs:
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing

Heart:
_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Shortness of Breath
_____ Chest Pain

Digestive Tract:
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain

Other:
_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge

Grand Total: *(total ALL boxes here)*

HEALTH INVENTORY (Continued)

FAMILY HISTORY

At our office we are not only interested in your health and wellbeing, but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother(s): _____

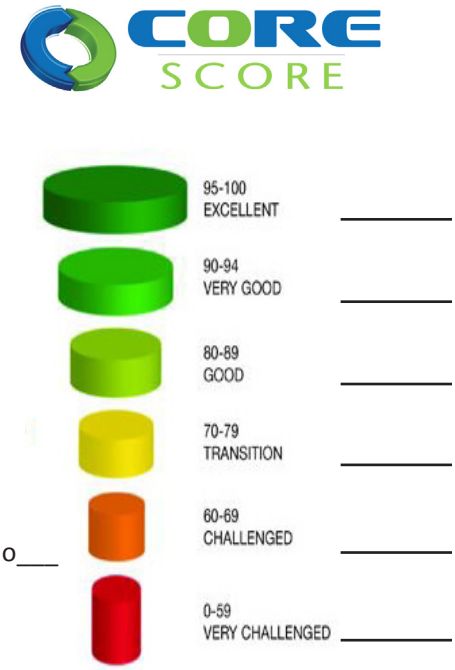
Sister(s): _____

HEALTH AND WELLNESS GOALS

1. On a scale of 1-10 (10 being most important), how important is your health to you? _____

On the CORESCORE chart to the right:

2. Please put an "X" next to the score where you feel your health is today.
3. Please circle where you would like to be (your goal).
4. How long do you think it might take to reach your goal?
   _____ Days _____ Weeks _____ Months _____ Years
5. What things might you need to change to help you reach your goal?
   _____
   _____
   _____
   _____



6. If we could make recommendations that would not only address your primary concerns, but could also help you with improving your overall health, would you like to hear them? Yes _____ No _____

- If there is a need for dietary changes would you like to know? Yes___ No___
- If there is a need for nutritional supplementation would you like to know? Yes___ No___
- If there is a need for specific exercises would you like to know? Yes___ No___
- If there is a need for support in the pyschological, mind/body stress management dimension of health would you like assistance? Yes___ No___

The above is accurate to the best of my knowledge.

_____ _____

Signature of Patient Date

I, parent/guardian, give permission for minor's care.

_____ _____

Signature of Parent/Guardian Date