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**Adult Health History-18 to present**

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	Yes	No	Explain	
Do/did you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your stress level (0=none/10=extreme)

Occupational\_\_\_\_\_ Personal\_\_\_\_\_

### Current Condition

Briefly describe your current symptoms/condition\_\_\_\_\_

\_\_\_\_\_

Was injury or pain due to Home , Work , or Auto Accident ?

The pain you are experiencing is  Sharp  Dull  Comes and goes  Constant  Travels

What makes symptoms worse \_\_\_\_\_

What makes them better \_\_\_\_\_

It interferes with  Work  Sleep  Walking  Sitting  Standing  Hobbies  Leisure

On a scale of 1(minimal)-10 (worst possible pain), my pain is \_\_\_\_\_/10

Other doctors seen for this condition:

Chiropractor\_\_\_\_\_

Medical doctor\_\_\_\_\_

Other\_\_\_\_\_

List any medication or natural supplements or vitamins you are taking and why:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Review of Systems

Have you had any past or present health concerns with the following? If yes, please list dates and explain.

	Yes	No	Unsure	Explain
1. Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

- 3. Ears
- 4. Nose/Sinus    \_\_\_\_\_
- 5. Throat
- 6. Heart/Circulation    \_\_\_\_\_
- 7. Lungs
- 8. Digestion/Stomach or bowels    \_\_\_\_\_
- 9. Urination/bladder
- 10. Reproduction/Sexual Function    \_\_\_\_\_
- 11. Mental health    \_\_\_\_\_
- 12. Skin    \_\_\_\_\_
- 13. Numbness/Tingling    \_\_\_\_\_
- 14. Neuromusculoskeletal    \_\_\_\_\_

Family History

- 1. Heart disease \_\_\_\_\_
- 2. Diabetes \_\_\_\_\_
- 3. Cancer \_\_\_\_\_

*These statements are accurate to the best of my knowledge.*

\_\_\_\_\_

Signed

\_\_\_\_\_

date