ADULT HEALTH HISTORY FORM 17 YEARS AND OLDER Date: ______________________

At Parascak Family Chiropractic we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you into this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Daily, we experience physical, emotional, and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

Referred to our office by: ______________________________

Last Name: ______________________ First Name: ______________________

Address: ______________________________ City: ______________________

Postal Code: ______________ Email (for in office use only) : ______________________

Home #: ______________ Cell #: ______________ Work #: ______________

Occupation: ______________________ Employer: ______________________

Extended Health Care Insurance: □ Yes □ No Alberta Health Care #: ______________________

Date of Birth (YYYY/MM/DD): ______________________ Age: __________ Sex: □ M □ F

Reason for Initial Visit: □ WCB Claim □ MVA Claim □ Chiropractic Spinal Check

Marital Status: □ S □ M □ D □ W Spouse's Name: ______________________________

# of children: _______ Children's names and ages: ______________________________

____

____

THE BEGINNING YEARS (up to age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood History

- □ Born by Vacuum
- □ Born by Forceps
- □ Born by Caesarean
- □ Born Breech
- □ Stomach sleeper as a child
- □ On Antibiotics as a child
- □ Used puffers as a child
- □ Vaccinations as a child

Childhood illnesses: ______________________________

____

Childhood surgeries: ______________________________

____

Childhood injuries, falls, car accidents: ______________________

____

Contact Sports: ______________________________

____

After Childhood – Present

- □ Smoke
- □ Drink Alcohol
- □ Eat unhealthy foods
- □ Little to no exercise
- □ Occupational stress
- □ Home Stress
- □ Physical Stress
- □ Computer (home or work)
- □ Sit at work mostly
- □ Stand at work mostly
- □ Stomach sleeper

ADULT YEARS (18-Present)

Surgeries______________________________

____

# of Medications/day______________________________

What do you take medications for?

1) ______________________ 2) ______________________

3) ______________________ 4) ______________________

Sports/Hobbies______________________________

____

Car Accidents _____ When______________________

Describe______________________________

Falls/Injuries ______________ When______________

Describe______________________________

____

CURRENT LIFESTYLE

Your current lifestyle determines how healthy you are now and how well your body will heal.
Please rate your current health on a scale of **0 (poor) – 10 (optimal)**.

Diet __________ Exercise ___________ Sleep ____________ Emotional/spiritual ____________

Many times, symptoms indicate a long-standing spinal condition. Please check off any symptoms you have now or have experienced in the past.

Past	Present		Past	Present	
□	□	Headaches	□	□	Difficulty Breathing/sinuses
□	□	Fatigue	□	□	Asthma
□	□	Irritability	□	□	Frequent colds/flues
□	□	Depression	□	□	Ulcers
□	□	Neck Pain	□	□	Digestive problems
□	□	Dizziness	□	□	Low Back/Hip Pain
□	□	Loss of Concentration	□	□	Constipation
□	□	Difficulty Sleeping	□	□	Diarrhea
□	□	Mid Back Pain	□	□	Menstrual pain
□	□	Arm/hand pain or numbness	□	□	Leg/foot pain or numbness
□	□	Chest pain	□	□	Cancer
□	□	Heart Problems	□	□	Diabetes
□	□	Heartburn	□	□	Stroke
□	□	Skin problems	□	□	Bladder/urinary tract problems

Please describe the location of your symptoms or reasons for making this appointment: ______________
____
How long have you had this condition? ____
Have you had a similar condition in the past? ____
What makes it worse? ____
What relieves it? ____
Do you feel your symptoms have been getting: □ better □ same □ worse?
Is the pain: □ sharp □ dull □ burning □ tight □ throbbing □ numb?
Is this condition interfering with your: □ work □ home routine □ family?
What doctors have you seen about this condition? ____________________________________
Have you seen a Chiropractor before? □ No □ Yes, when? ____________________________
Name:___________________________________ Approximately how many visits? ___________________
For women: Are you pregnant? □ Yes □ No □Trying □ Unsure Last period? ______________________

FAMILY HISTORY

	Heart Disease	Arthritis	Cancer	Diabetes
Father's side	□	□	□	□
Mother's side	□	□	□	□

Other: ____