



OAKTREE

CHIROPRACTIC
ACUPUNCTURE
CHINESE MEDICINE

Adult Chiropractic Health Form

PERSONAL INFORMATION

Name: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell #: _____ Office #: _____

Email: _____

Yes No I consent to receiving email communication from Oaktree
(Emails we will send you include news updates from Oaktree. We will not spam you and you can unsubscribe at anytime. You will still receive appointment reminders and other important notices via email)

Birth date: [M]_____ [D]_____ [Y]_____ Age: _____ Weight: _____ Height: _____

MD name: _____

Workplace: _____ Occupation: _____

Referred by: _____

Marital Status: Single Common law Married Divorced Separated Widowed

Do you have kids? Yes (Ages: _____) No

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? Yes No Were x-rays taken? Yes No

Name of Chiropractor: _____ City: _____

Date of last visit: [M]_____ [Y]_____ Duration & Frequency of Care: _____

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

Signature

Date



HEALTH CONCERNS

WHAT IS YOUR PRESENT PRIMARY HEALTH CONCERN? _____

Location: _____

How long have you had this condition?

Have you had a similar condition in the past?

What aggravates your condition?

What relieves your condition?

Are you getting pain or numbness in your arms or legs?
Details: _____

Is your condition getting progressively worse?
 Yes No It's constant It comes and goes

Pains are:
 Sharp Dull Burning Tightness

Pain severity (mark on line. 0=no pain, 10=severe)
Currently: 0.....10
At its worst: 0.....10

Other health care professionals who treated this condition? What else have you tried?

IF APPLICABLE, WHAT IS YOUR SECONDARY HEALTH CONCERN? _____

Location: _____

How long have you had this condition?

Have you had a similar condition in the past?

What aggravates your condition?

What relieves your condition?

Are you getting pain or numbness in your arms or legs?
Details: _____

Is your condition getting progressively worse?
 Yes No It's constant It comes and goes

Pains are:
 Sharp Dull Burning Tightness

Pain severity (mark on line. 0=no pain, 10=severe)
Currently: 0.....10
At its worst: 0.....10

Other health care professionals who treated this condition? What else have you tried?

***What is this affecting that is MOST important in your life? (list all that apply)**

What health goal, if you were to complete it or accomplish it, would have the greatest impact on your life?



CONDITIONS & SYMPTOMS

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DID YOU KNOW EACH HEALTH CONCERN MAY RELATE TO A SPECIFIC AREA OF THE SPINE AND NERVOUS SYSTEM?

PLEASE CHECK OFF ANY BOXES BELOW THAT YOU ARE EXPERIENCING.

Head / Neck

- Blurred / failing vision
- Deafness / ringing in ears
- Earaches
- Sore Throat / tonsillitis
- Thyroid problems
- Sinus problems
- Environmental allergies

Cardiovascular system

- Chest pain
- Shortness of breath
- Heart medication
- High blood pressure medication
- High cholesterol medication
- Swelling of legs

Respiratory system

- Frequent bronchitis
- History of pneumonia
- Chronic cough
- Spitting up phlegm / blood
- Difficulty breathing
- Tuberculosis
- Pneumonia
- Asthma

Digestive system

- Heartburn / indigestion
- Stomach cramps
- Constipation / diarrhea
- Food allergy: _____
- Food intolerances: _____
- Irritable bowel syndrome
- Crohn's disease
- Ulcers
- Belching / gas
- Nausea or vomiting
- Liver / gall bladder problems
- Colon trouble
- Black / bloody stool

Females only

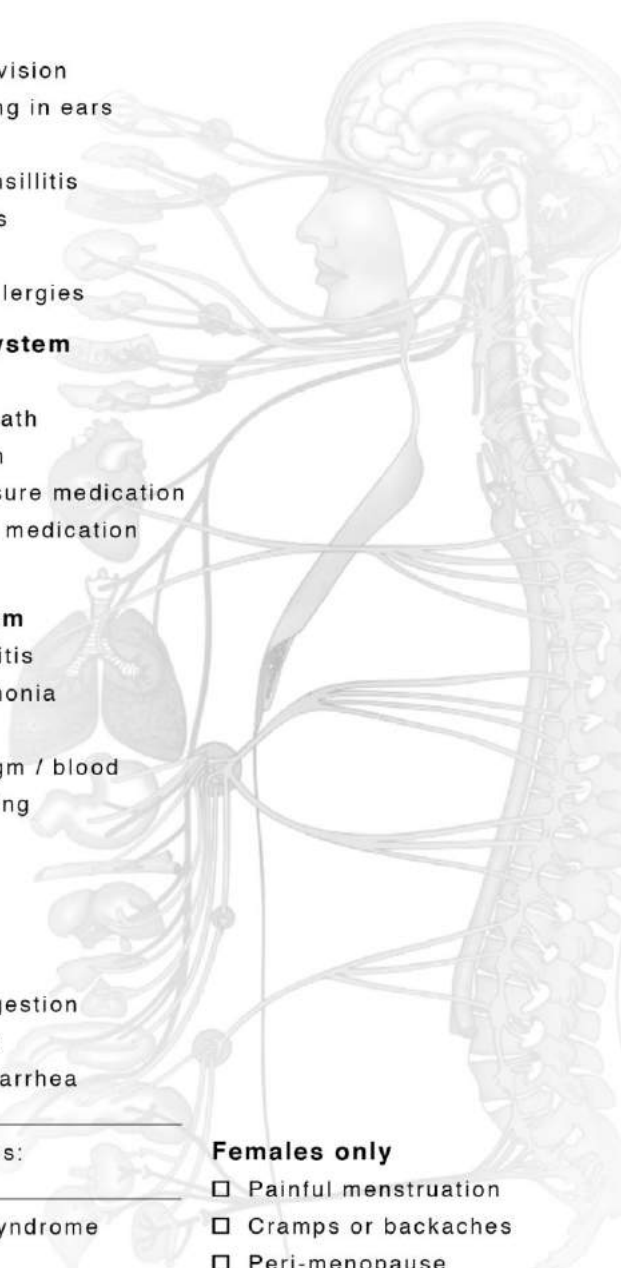
- Painful menstruation
- Cramps or backaches
- Peri-menopause
- Passed menopause
- Currently pregnant: Y N
- Excessive / irregular flow
- Abnormal discharge
- Miscarriages # _____
- Date of last menstrual period _____

Musculoskeletal system

- Painful joints
- Painful muscles
- Tendinitis (location) _____
- Bursitis (location) _____
- Arthritis (location) _____
- Headaches / migraine
- Neck pain / stiffness
- Tension across shoulders, L R
- Numbness-tingling: arms/hands, L R
- Numbness-tingling: legs/feet, L R
- Mid-back pain / stiffness
- Lower-back pain / stiffness
- Scoliosis / spinal curvatures
- Faulty posture
- Painful tailbone
- Foot trouble, L R

General symptoms

- Fever / chills / sweats
- Frequent colds
- Fainting / dizziness
- Seizures / convulsions
- Skin problems
- Tremors
- Loss of balance
- Unexpected weight loss / gain
- Anemia
- Alcoholism
- HIV / AIDS
- Loss of sleep
- Poor memory / concentration
- Learning disability
- Irritable / nervous / tension
- Depression / emotional problems
- Anxiety
- Decreased energy / fatigue
- Tired / lethargic
- Autoimmune disease
- Antibiotic use
- Cancer: _____
- Other: _____





PREVIOUS TRAUMAS

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MOTORIZED VEHICLE ACCIDENTS

Year: Description:

Any injuries:

Year: Description:

Any injuries:

FALLS & INJURIES (REGARDLESS OF AGE)

Falls from heights:

Falls down stairs:

Other falls:

Broken bones:

Childhood falls:

Other injuries:

POSTURE & HABITS:

- Posture and habits checklist including sitting >6 hours/day, stomach sleeper, head forward posture, computer/phone >3 hours/day, repetitive activities, serving/catering, crafting, leaning on one hip, cross legs often, and a blank checkbox.

SPORTS & RECREATION:

Sports or recreation injuries:

Participation in High Impact Activities:

- Checkboxes for Hockey, Wrestling, Basketball, Running, Mountain Bike, Climbing, Football, Gymnastics, and a blank checkbox.

OCCUPATIONAL STRESSES

Occupation:

My job requires:

- Checkboxes for Heavy lifting, Awkward positions, Repetitive stresses, and Sitting for long periods.

Previous applicable occupation:

Tasks:

Work Injuries:

BIRTH TRAUMA

Was your own birth:

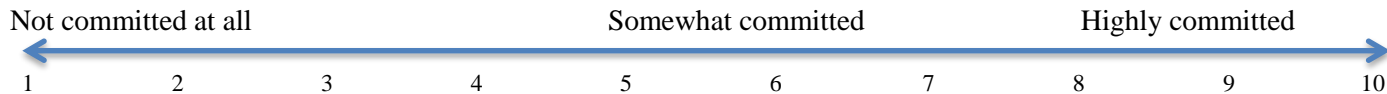
- Checkboxes for Difficult/long, Forceps, C-section, Epidural, Suction, Resuscitation.

Have you ever given birth? Was it:

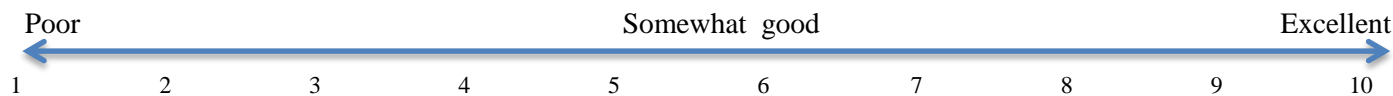
- Checkboxes for Difficult/long, Forceps, C-section, Epidural, Suction, Resuscitation.

How many births have you had:

Commitment to Health:



Overall Health:





DISEASE CAUSATION ANALYSIS

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EXERCISE

How often do you participate in aerobic exercises?
(at least 30 minutes per day)

- 0 days/week 1-2 days/week
- 3-4 days/week 5-7 days/week

Do you lift weights or do resistance training?

- Crossfit Gym Other: _____

How often do you stretch per week?

- 0 days/week 1-2 days/week
- 3-4 days/week 5-7 days/week

EMOTIONAL STRESS

Are you currently experiencing stress in the following areas?

- Marriage _____
- Kids _____
- Finances _____
- Work _____
- Elderly parents – caregiver _____
- Recent major life events (births, deaths...)

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

- Parents: _____
- _____
- Siblings: _____
- _____

EQUIPMENT

Mattress age: ___ Comfortable Uncomfortable

Type: Coil Foam Rubber

Pillow: Ergonomic neck support Feather
 Foam Other: _____

Do you wear?: Custom orthotics

- Over the counter foot orthotics
- Foot lifts (height: _____)
- Heel lifts (height: _____)
- Over the counter foot supports

CHEMICAL STRESSES

Do you feel that you make healthy food choices?

- Yes No Don't know

How would you describe your nutrition?: _____

Are you at your ideal body weight?

- Yes No Don't know

Do you take any supplements? Yes No

Which: Omega 3 Vitamin B Probiotics

Vitamin D Multivitamin Iron

Other: _____

Do you presently:

- Smoke Use recreational drugs
- Have a history of addiction (please explain)

Do you consume alcohol? Yes No

How often?

- 1-3 days/week Daily More than 1x per day

MEDICAL HISTORY

HEALTH CONDITIONS

Please list current diagnoses: _____

MEDICATIONS

Name and for which condition(s)?

- _____
- _____
- _____

SURGERIES

For what condition(s)? (include year preformed)

- _____
- _____
- _____

Any other details that may assist the Doctor in understanding your lifestyle and health status:

- _____
- _____
- _____