Adult New Patient Health History

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AUTHENTIC HEALTH

Name: _____

DOB: _____ Date: _____

Primary Concerns/Goals: 1. _____

2. _____ 3. _____

When did it start and what therapies have you tried for it? _____

List all medications currently taking _____

List all supplements currently taking _____

Vegetarian? ☐ Y ☐ N Type: _____ Metal in your body (fillings, staples, pins, etc)? ☐ Y ☐ N Type: _____

Allergies? ☐ Y ☐ N Details: _____

Car Accidents? ☐ Y ☐ N Details: _____

Hospitalizations / Surgeries? ☐ Y ☐ N Details: _____

Hx of Head Trauma/Concussion/Spinal Trauma? ☐ Y ☐ N Details: _____

Broken Bones / Dislocations? ☐ Y ☐ N Details: _____

Hx of Abuse: ☐ Physical ☐ Mental ☐ Emotional ☐ Sexual _____

Family Hx of Disease (Diabetes, Heart Disease, Cancer, etc): _____

Previous Chiropractic Care: ☐ Last visit: _____ Blood type: _____

Mark "C" for CURRENT problems and "P" for problems you've had in the PAST

- ☐ Ulcer
- ☐ Hiatal Hernia
- ☐ Food intolerance: ☐
- ☐ Chrons / Colitis / IBS
- ☐ Asthma
- ☐ URI / Bronchitis ☐x
- ☐ Pneumonia ☐x
- ☐ Emphysema
- ☐ Ear Infections ☐x
- ☐ Strep throat ☐x
- ☐ Root Canal(s) ☐x
- ☐ Staph infection / MRSA
- ☐ Mononucleosis
- ☐ Measles / Mumps
- ☐ Autoimmune Disease
- ☐ Diabetes
- ☐ Low Thyroid
- ☐ Neurological problems

- ☐ Cancer: Type: ☐
- ☐ Learning Disability
- ☐ Addiction: ☐
- ☐ Eating Disorder: ☐
- ☐ Eye problems: ☐
- ☐ Near-sighted / Far-sighted
- ☐ Hearing Loss
- ☐ Sleep Apnea / CPAP use
- ☐ Insomnia
- ☐ Osteoporosis / Osteopenia
- ☐ Arthritis: ☐
- ☐ Gout
- ☐ Psoriasis / Eczema
- ☐ Varicose / Spider Veins
- ☐ Heart issues: ☐
- ☐ High / Low Blood pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Incontinence
- ☐ Kidney stones
- ☐ STD: ☐

MALE ONLY

- ☐ Infertility
- ☐ Benign Prostatic Hyperplasia
- ☐ PSA # ☐

FEMALE ONLY

- ☐ Birth control
- ☐ Infertility
- ☐ Endometriosis
- ☐ Fibrocystic Breast
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Yeast Infection
- ☐ Pelvic Inflam Disease
- ☐ Abnormal Pap
- ☐ Menopause
- ☐ PCOS
- ☐ Pregnant
- ☐ Actively trying to be pregnant?
- ☐ # of Live birth ☐
- ☐ # of Pregnancies ☐

TRAVEL HISTORY

- ☐ Mexico / Central America
- ☐ India / Southeast Asia
- ☐ Africa

PAIN/STIFFNESS/SWELLING NUMBNESS/TINGLING

- ☐ TMJ (R / L)
- ☐ Neck (R / L)
- ☐ Upper Back (R / L)
- ☐ Shoulders (R / L)
- ☐ Elbows/Wrist/Hand (R / L)
- ☐ Mid Back (R / L)
- ☐ Low Back (R / L)
- ☐ SI Joint (R / L)
- ☐ Hips (R / L)
- ☐ Sciatica (R / L)
- ☐ Legs (R / L)
- ☐ Knees/Ankles/Feet (R / L)
- ☐ Other: ☐

System Review

___ Stress: scale 1-10
___ Bowel Movement: x /wk
___ Water: oz / day
___ Juice: glasses / day
___ Coffee: cups / day
___ Soda: oz / day
___ Alcohol: glasses / wk
___ Tobacco: x / day
☐ Soy Use: _____
☐ Artificial Sweetener Use:
☐ Equal (Aspartame)
☐ Splenda (Sucralose)
___ Cardio: x / wk
___ Weight Train: x / wk
___ Yoga/Pilates: x / wk
___ Sports: hrs / wk

Rank any symptoms you are currently having 1 - 10 or check applicable boxes.

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ache / Infection
___ Draining
___ Itchy
___ Dizziness/Vertigo
___ Excessive Ear Wax
___ Other _____

EYES
___ Burn / Tear / Itchy
___ Ache / Dry / Red
___ Crust in am / Film
___ Bouts of Blurriness
___ Floaters / Spots
___ Tired / Puffy
___ Stye
___ Twitching around eye
___ Dark circles
___ Light sensitive
___ Other _____

SINUS
___ Nosebleeds
___ Dry
___ Drain
___ Stuffy/plugged
___ Sneeze frequently
___ Taste / Smell loss
___ Post nasal drip

SKIN/HAIR/NAILS
___ Skin: _____
___ Acne: _____
___ Butt Acne
___ Dry skin
___ Eczema / Psoriasis
___ Nails (white spots /ridges)
___ Nails (weak / peeling)
___ Hair loss
___ Limp Hair
___ Damp hands / feet
___ Dandruff
___ Red dots
___ Bruise easily
___ Bumps on Back of Arms
___ Missing outer 1/3 of eyebrow
___ Cold hands / feet
___ Ingrown toenails
___ Other _____

___ = 1-10
☐ = ✓
_____ = Further details

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Ache / Cramps
___ Nausea/Vomiting
___ Bloat After Eat
___ Gas / Flatulence
___ Belching
___ Other _____

BOWEL
___ Diarrhea
___ Constipation
___ Incomplete
___ Bulky
___ Cramps in Abdomen
___ Pain w/ Bowel Movement
☐ Laxative / Suppository Use
☐ Colonics / Enemas
___ Anal Itching
___ Hemorrhoids:
___ Swollen / Achy
___ Burning / Itchy
___ Blood
___ Other _____

STOOL CONSISTENCY
☐ Normal _____ %
___ Light colored feces
___ Soft
___ Fluffy
___ Hard
___ Pebbles
___ Ribbon-like
___ Mucous
___ Contain string-like black/white specks
___ Contain undigested food

APPETITE/DIET
☐ Low ☐ Normal ☐ High
___ Crave Starch / Sweets
___ Crave Salt
___ Crave Chocolate / Ice Cream
___ Eat lots of spicy foods
___ Nighttime snack: _____
If meals are missed:
___ Nausea
___ Extreme hunger
___ Cold / Clammy
___ Rapid heartbeat
___ Irritability
___ Light headed

LIBIDO/SEXUALITY
☐ Low ☐ Normal ☐ High
Orgasms:
☐ None ☐ Poor ☐ Good ☐ Great

CHEST
___ Tension / Tight
___ Pressure / Heaviness
___ Congestion
___ Chest / Sternal Pain
___ Palpitations-Heart Skip
___ Heart Racing / Slowing
___ Other: _____

RESPIRATORY
___ Short of breath: Constant
___ Short of breath: Exertion
___ Wheeze
___ Air hunger / yawn
___ Frequent Sighs
___ Upper Resp Infx
___ Asthma
___ Other: _____

SLEEP
Quality of Sleep:
☐ Poor ☐ Good ☐ Great
Hours in bed: _____
Hours asleep: _____
☐ Interrupted____/night
☐ Waking at ____ AM
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Crave sleep during day
___ Awaken Suddenly (Jolt)
☐ Don't dream
___ Nightmares / Epic dreams
___ Night sweats
___ Restlessness
___ Restless Leg Syndrome

EMOTIONS
___ Sadness / Depression
___ Moodiness / Irritable
___ Frustrated / Angry
___ Nervous / Anxiety
___ Grief
___ Panic / Fear
___ Cry
___ S.A.D.
___ OCD
___ Other: _____

HEADACHES
___ Base of Skull (back)
___ Side of Head (temples)
___ Frontal (above eyes)
___ Top of Head
___ Entire Head
___ Migraines

COGNITION
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other: _____

ENERGY
☐ Norm ☐ Low ☐ Variable ☐ High
___ Slow to start in am
___ Low energy after meals
___ Energy crash at ___ am/pm
___ Other: _____

URINATION
___ X during the night
___ Urgency
___ Burning/Pain
___ Odor/Foamy
___ Dark color
___ Incontinence
___ Urinary tract infection
___ Kidney troubles
___ Other: _____

MALE ONLY
___ Erectile Dysfunction
___ Prostate Problems
___ Burn
___ Achy / Pain
___ Restriction / Swelling
___ Other: _____

FEMALE ONLY
☐ Menopause
Date Last Period: _____
Cycle Length (28-30 days): _____
# of Days of Flow: _____
Cramps: ☐ mild ☐ mod ☐ severe
PMS: ☐ mild ☐ mod ☐ severe
___ Vaginal Itching / Discharge
___ Heavy flow
___ Large clots
___ Yeast Infection
___ Hot Flashes
___ Vaginal Dryness
___ Painful Intercourse
___ Other: _____

OTHER HEALTH ISSUES