



# Integrated Health Solutions

## Adult Health History

(Ages 13 +)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Children's Names: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Enrolled in Medicare?  Yes  No E-Mail: \_\_\_\_\_

Would you like to receive Mountain Valley Chiropractic news & announcements via e-mail?  Yes  No

Is today's visit due to:  Illness  Accident  Injury  Other \_\_\_\_\_

Job related?  Yes  No Automobile related?  Yes  No

Chief Complaint: \_\_\_\_\_

Circle the type of pain: Sharp Dull Burning Achy Throbbing Numb

How and when did it start? \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Have you been treated for this condition before?  Yes  No If yes, by whom? \_\_\_\_\_

Are you currently under a healthcare provider's care for any other problems?  Yes  No

Previous Chiropractic Care: Last visit? Reason? Duration of care? \_\_\_\_\_

Current Medications/Supplements: \_\_\_\_\_

Hospital/ER Visits/Surgeries? \_\_\_\_\_

Other Injuries/Accidents: \_\_\_\_\_

Rate the Following:	Poor		Average		Exceptional
General Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall Diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise Routine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What Physical Stresses have you experienced recently? \_\_\_\_\_

Emotional Stresses (Grief, Loss, Fear, Family, Money, etc.)? \_\_\_\_\_

Chemical Stresses - Do you smoke?  Yes  No  Never Packs/day? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use alcohol?  Yes  No  Never Drinks/day? \_\_\_\_\_ per week? \_\_\_\_\_

Do you use recreational drugs?  Yes  No  Never How often? \_\_\_\_\_

**Did you experience any of the following during your childhood years? (circle one):**

Illnesses/Frequent Colds/Ear Infections?	Y	N	Don't Know
Medication/Antibiotics/Inhaler?	Y	N	Don't Know
Falls/Injuries?	Y	N	Don't Know
Hospitalizations/Surgeries?	Y	N	Don't Know
Braces?	Y	N	Don't Know
Physical/Emotional Trauma?	Y	N	Don't Know
Car Accidents?	Y	N	Don't Know
Difficult Birth (breech, forceps, vacuum, c-section)?	Y	N	Don't Know
Vaccine Reactions (fever, seizures, personality changes)?	Y	N	Don't Know

**Have you or anyone in your immediate family experienced the following now OR in the past?**

*Check **O** for You. Check  for Immediate Family. Fill in type of condition on the line next to illness.*

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism/Substance Abuse                   | <input type="checkbox"/> Herpes _____                               |
| <input type="checkbox"/> Allergies _____                              | <input type="checkbox"/> Inflammation or Arthritis                  |
| <input type="checkbox"/> AIDS/HIV                                     | <input type="checkbox"/> Insomnia or Sleeping Problems              |
| <input type="checkbox"/> Anemia                                       | <input type="checkbox"/> Kidney Disease                             |
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Learning Challenges _____                  |
| <input type="checkbox"/> Attention Deficit Disorder                   | <input type="checkbox"/> Lymphatic Blockage                         |
| <input type="checkbox"/> Auto or Whiplash Injuries                    | <input type="checkbox"/> Menopause                                  |
| <input type="checkbox"/> Back Pain, Spine, or Disc Problems           | <input type="checkbox"/> Mental Illness _____                       |
| <input type="checkbox"/> Bedwetting                                   | <input type="checkbox"/> Migraine, Stress or Tension Headaches      |
| <input type="checkbox"/> Blood Pressure Problems                      | <input type="checkbox"/> Multiple Sclerosis                         |
| <input type="checkbox"/> Bursitis                                     | <input type="checkbox"/> Neck Pain and Stiffness                    |
| <input type="checkbox"/> Cancer _____                                 | <input type="checkbox"/> Pinched Nerves                             |
| <input type="checkbox"/> Colds or Ear Infections                      | <input type="checkbox"/> PMS  |
| <input type="checkbox"/> Constipation or Diarrhea                     | <input type="checkbox"/> Poor Circulation                           |
| <input type="checkbox"/> Depression, Fatigue, or Lack of Energy       | <input type="checkbox"/> Pregnancy and Fertility                    |
| <input type="checkbox"/> Diabetes Type _____                          | <input type="checkbox"/> Prostate Problems                          |
| <input type="checkbox"/> Digestive Disorders _____                    | <input type="checkbox"/> Sciatica                                   |
| <input type="checkbox"/> Dizziness or Loss of Consciousness           | <input type="checkbox"/> Shoulder or Arm Pain, Numbness or Tingling |
| <input type="checkbox"/> Emphysema                                    | <input type="checkbox"/> Spinal Curvature                           |
| <input type="checkbox"/> Epilepsy or Seizures                         | <input type="checkbox"/> Stress, Anxiety or Nervousness             |
| <input type="checkbox"/> Fibromyalgia                                 | <input type="checkbox"/> Stroke or TIA                              |
| <input type="checkbox"/> GERD or Heartburn                            | <input type="checkbox"/> Thyroid Disease                            |
| <input type="checkbox"/> Gout   | <input type="checkbox"/> Tinnitus (ringing in ears)                 |
| <input type="checkbox"/> Hand or Wrist Pain or Carpal Tunnel          | <input type="checkbox"/> Tuberculosis                               |
| <input type="checkbox"/> Heavy Metals                                 | <input type="checkbox"/> Ulcers                                     |
| <input type="checkbox"/> Hip, Knee or Foot Pain, Numbness or Tingling | <input type="checkbox"/> Urinary Problems                           |
| <input type="checkbox"/> Hormone Balance and Related Concerns         | <input type="checkbox"/> Weakened Immune System                     |
| <input type="checkbox"/> Heart Disease or Heart Failure               | <input type="checkbox"/> Work-Related Injuries                      |
| <input type="checkbox"/> Hepatitis _____                              | <input type="checkbox"/> Yeast/Fungus/Mold/Parasites                |

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_