River City CHIROPRACTIC

Adult Health History Form

4311 W 6th Street, Ste C
Lawrence, KS 66049
785-856-0423

PERSONAL DATA:

Today's Date _____

Name (first middle last) _____ Preferred Name _____

Both Parent's names (if you are under 18)_____

Home Address _____ City _____ State _____ Zip _____

Cell (____) _____ Work (____) _____ Home (____) _____

E-mail address _____ Gender: M / F Marital Status _____

SS#_____ Date of Birth _____ Race _____

Occupation _____ Employer _____

Emergency Contact _____ Primary Phone _____

Secondary Phone _____ Relation to Patient _____

Referred by _____ Family / Friend / Co-Worker / Doctor / Other

HEALTH CARE PRACTITIONER HISTORY:

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? _____ Date of last visit _____ Reason for Care _____

Why did you stop care? _____

Primary Care Physician _____ Doctor's Phone _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ 1. Medical Physician ❑ 3. Naturopath ❑ 5. Acupuncturist ❑ 7. Homeopath
❑ 2. Massage Therapist ❑ 4. Psychotherapist ❑ 6. Energy Healer ❑ 8. Dentist

Reason & Response to care (please list number) _____
_____
_____
_____

FINANCIAL INFORMATION:

❑ Insurance ❑ Self-Pay ❑ Worker's Comp ❑ Personal Injury/Auto

Who is responsible for payment? Self / Other - (*Relation to Patient*) _____

If other: Name (First, MI, Last) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Insurance

Insurance Name _____
Relation to Insured: Self / Spouse / Parent / Child / Other
If the Insured is other than Self:

Insured's Name: _____
Gender: M / F Date of Birth _____
Phone _____
Address _____
City _____ State _____ Zip _____

Secondary Insurance

Insurance Name _____
Relation to Insured: Self / Spouse / Parent / Child / Other
If the Insured is other than Self:

Insured's Name: _____
Gender: M / F Date of Birth _____
Phone _____
Address _____
City _____ State _____ Zip _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Adult Health History Cont.

River City CHIROPRACTIC

REASON FOR SEEKING CHIROPRACTIC CARE:

Pick all areas you are interested in receiving or learning more information about:

❑ Pain Relief	❑ Nutrition	❑ Kinesiology Taping (RockTape)	❑ Acupuncture	❑ Posture
❑ Exercise Plan	❑ Leaky Gut	❑ Reducing Lifestyle Toxins	❑ Body Cleanse	❑ Massage
❑ Relief & Prevention of Symptoms		❑ Healthier spine & nerve system	❑ Optimal Health	❑ Other

Describe Major Complaint _____

Describe WHEN and HOW this began _____

_____

Quality of Complaint ❑ Sharp ❑ Stabbing ❑ Burning ❑ Achy ❑ Dull ❑ Stiff & Sore ❑ Other

Does this complaint radiate/shoot to any areas of your body? ❑ No ❑ Yes -*Location* _____

Severity of Complaint ❑ None (0) ❑Mild (1-2) ❑Mild-Mod (2-4) ❑Moderate (4-6) ❑Mod-Severe (6-8) ❑Severe (8-10)

Frequency ❑ Always ❑ Hourly ❑ Daily ❑ Occasionally

Daily activities affected by this condition (Please check all that apply)

❑ Work/School	❑ Exercise/Sports	❑ Driving	❑ Walking	❑ Sleep
❑ Sitting	❑ Stairs	❑ Love Life	❑ Eating	❑ Other activities

Please explain _____

Aggravates Condition ❑ Sit ❑ Stand ❑ Walk ❑ Lying ❑ Sleep ❑ Overuse ❑ Other _____

Improves Condition ❑ Ice ❑ Heat ❑ Rest ❑ Movement ❑Stretching ❑ OTC Meds ❑ Other _____

For this CURRENT condition, have you:

Received any treatment? ❑ None ❑ DC ❑ MD ❑ PT ❑ Massage ❑ ER ❑ Other _____

If yes, explain _____

Diagnostic Testing? ❑ None ❑ X-Rays ❑ MRI ❑ CT ❑ Other _____

Describe Additional Complaints _____

_____

_____

FAMILY MEDICAL HISTORY: List major health issues of grandparents, parents, siblings, and your children

Problem	Relation	Treatment	Outcome

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

The following information will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life. These can affect your current spinal, nerve and health status. The physical, emotional, and chemical stresses may be the cause of **Vertebral Subluxations**.

I have read the above statement (signature required) _____

Adult Health History Cont.

River City CHIROPRACTIC

PHYSICAL STRESS:

Check all that apply to your life currently: ❑ Exercise ❑ Hobbies ❑ Recreational Activities ❑ Active at Work
How do you grade your Physical Health: ❑ Good ❑ Fair ❑ Poor

BIRTH: Birth may traumatize a baby's spine & cause damage to the nerve system. Check all that apply to your birth.
❑ Home Birth ❑ Natural ❑ Hospital Birth ❑ Caesarian Section ❑ Drug Induced Labor
❑ Breech ❑ Suction ❑ Forceps ❑ Prolonged Labor ❑ Cord around neck

CHILDHOOD THROUGH ADULT: Minor & repetitive physical traumas we endure are often too numerous to list.
Please list all major traumas that you remember from your childhood up to the present. (Check all that apply)
❑ Auto Accident ❑ Concussion ❑ Bicycle Accident ❑ Sports Injury ❑ Playground Accident
❑ Broken Bone ❑ Sprain ❑ Hospitalized ❑ Surgery ❑ Abuse ❑ Other

Date	Describe Accident, Injury, Hospitalization, or Surgery	Outcome

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs.
Please check if you have ever or are experiencing any of the emotional stresses below:
❑ Childhood Trauma ❑ Loss of Loved One ❑ Emotional Abuse ❑ Work/School Stress ❑ Illness
❑ Financial Stress ❑ Lifestyle Change ❑ Divorce/Separation ❑ Parents' Divorce ❑ Other
How do you grade your Emotional / Mental Health: ❑ Good ❑ Fair ❑ Poor
How do you grade your Social Health: ❑ Good ❑ Fair ❑ Poor

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, chemicals in the air, etc.) The following will reveal exposures:

Vaccinated as a child? ❑ Yes ❑ No As an adult? ❑ Yes ❑ No If yes, any reactions? ❑ Yes ❑ No ❑ Unsure
Allergies or Sensitivities to foods? ❑ Yes ❑ No If yes, which ones & reactions: _____
_____
Allergies or Sensitivities to medication? ❑ Yes ❑ No If yes, which ones & reactions: _____
_____

Note: It is imperative that you list all medications as they may have an influence on your care.

Name of Medication (OTC/Rx) or Supplement	Dosage	Frequency	Method	Reason for Taking

Diet Includes (check all that apply): ❑ Homemade Food ❑ Processed Food ❑ Diet Food Products ❑ Fast Food
Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Mold	❑ Perfume	❑ Scented Candles	❑ Air Freshener/Plug-ins	❑ Drug Therapy
❑ Lotions	❑ Bleach	❑ Beauty Products	❑ Household Cleaning Products	❑ Plastic Use
❑ Antibiotic Use	❑ Nursed	❑ Formula Fed	❑ Recreational Drugs	❑ Dryer Sheets
❑ Tobacco Use	❑ Radiation	❑ Smoke	❑ Secondhand Smoke	❑ Alcohol Use
❑ Caffeine	❑ Soda	❑ Coffee	❑ Chemicals at work	❑ Other

Exposure	Frequency	Amount	Exposure	Frequency	Amount

Adult Health History Cont.

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REVIEW OF SYSTEMS: Check ❑C for all symptoms that are CURRENT and ❑H for symptoms you've had a HISTORY of. **MANY OF THESE CONDITIONS RESPOND TO CHIROPRACTIC AND ACUPUNCTURE TREATMENT**

GENERAL/MIND/STRESS:
- ❑C ❑H Recent Weight Change
- ❑C ❑H Fever
- ❑C ❑H Fatigue
- ❑C ❑H Cancer
- ❑C ❑H Eating Disorder
- ❑C ❑H Alcoholism
- ❑C ❑H Nervousness
- ❑C ❑H Depression
- ❑C ❑H Sleep Problems
- ❑C ❑H Memory Loss
- ❑ *NONE IN CATEGORY*

MUSCULOSKELETAL:
- ❑C ❑H Low Back Pain
- ❑C ❑H Mid Back Pain
- ❑C ❑H Neck Pain
- ❑C ❑H Arm Problems
- ❑C ❑H Leg Problems
- ❑C ❑H Painful Joints
- ❑C ❑H Stiff/Swollen Joints
- ❑C ❑H Sore/Weak Muscles or Joints
- ❑C ❑H Muscle Spasms or Cramps
- ❑C ❑H Sciatica
- ❑C ❑H Scoliosis
- ❑ *NONE IN CATEGORY*

NEUROLOGICAL:
- ❑C ❑H Numbness or Tingling Sensation
- ❑C ❑H Loss of Feeling
- ❑C ❑H Dizziness or Light Headed
- ❑C ❑H Headaches
- ❑C ❑H Convulsions or Seizures
- ❑C ❑H Tremors
- ❑C ❑H Stroke
- ❑ *NONE IN CATEGORY*

GENITOURINARY:
- ❑C ❑H Sexual Difficulty
- ❑C ❑H Venereal Disease
- ❑C ❑H Kidney Stones
- ❑C ❑H Burning/Painful Urination
- ❑C ❑H Change of Urination force/strain
- ❑C ❑H Blood in Urine
- ❑C ❑H Prostrate Trouble
- ❑ *NONE IN CATEGORY*

GASTROINTESTINAL:
- ❑C ❑H Loss of Appetite
- ❑C ❑H Ulcers
- ❑C ❑H Digestion Problems
- ❑C ❑H Constipation
- ❑C ❑H Diarrhea
- ❑C ❑H Abdominal Pain
- ❑C ❑H Blood in Stool
- ❑C ❑H Change in Bowel Movements
- ❑C ❑H Painful Bowel Movements
- ❑C ❑H Nausea or Vomiting
- ❑ *NONE IN CATEGORY*

CARDIOVASCULAR & HEART:
- ❑C ❑H Pacemaker
- ❑C ❑H Irregular Heartbeat
- ❑C ❑H Rapid Heartbeat
- ❑C ❑H Chest Pains
- ❑C ❑H Swelling of Hands, Ankles, Feet
- ❑C ❑H Heart Problems
- ❑C ❑H Arteriosclerosis
- ❑ *NONE IN CATEGORY*

RESPIRATORY:
- ❑C ❑H Difficulty Breathing
- ❑C ❑H Persistent Cough
- ❑C ❑H Coughing Blood
- ❑C ❑H Asthma or Wheezing
- ❑C ❑H Lung Problems
- ❑C ❑H Tuberculosis
- ❑C ❑H Bronchitis
- ❑C ❑H Shortness of Breath
- ❑ *NONE IN CATEGORY*

EYES & VISION:
- ❑C ❑H Contacts or Glasses
- ❑C ❑H Blurred or Double Vision
- ❑C ❑H Eye Pain
- ❑C ❑H Glaucoma
- ❑C ❑H Eye disease or Injury
- ❑ *NONE IN CATEGORY*

SKIN AND BREASTS:
- ❑C ❑H Rash or Itching
- ❑C ❑H Change in Hair or Nails
- ❑C ❑H Breast Pain, Lump, Discharge
- ❑ *NONE IN CATEGORY*

EARS, NOSE, THROAT:
- ❑C ❑H Bleeding Gums / Mouth Sores
- ❑C ❑H Bad Breath or Bad Taste
- ❑C ❑H Dental problems
- ❑C ❑H Swollen Throat
- ❑C ❑H Voice Change
- ❑C ❑H Swollen Glands in Neck
- ❑C ❑H Ringing in Ears
- ❑C ❑H Ear Ache
- ❑C ❑H Sinus Problems
- ❑C ❑H Allergies
- ❑C ❑H Nose Bleeds
- ❑C ❑H Loss of Smell
- ❑C ❑H Hearing Loss
- ❑ *NONE IN CATEGORY*

ENDOCRINE, BLOOD, LYMPH:
- ❑C ❑H Thyroid problems
- ❑C ❑H Diabetes
- ❑C ❑H Excessive Thirst / Urination
- ❑C ❑H Cold Extremities
- ❑C ❑H Heat or Cold Intolerance
- ❑C ❑H Change in Hat or Glove Size
- ❑C ❑H Dry Skin
- ❑C ❑H Glandular or Hormone Problem
- ❑C ❑H Swollen Glands
- ❑C ❑H Anemia
- ❑C ❑H Varicose Veins
- ❑C ❑H Bruise or Bleed Easily
- ❑C ❑H Phlebitis
- ❑C ❑H Transfusion
- ❑C ❑H Immune System Disorder
- ❑ *NONE IN CATEGORY*

WOMEN ONLY:

Last Period _____
- ❑C ❑H Infertility
- ❑C ❑H Excessive Menstruation
- ❑C ❑H Cramps/Painful Periods
- ❑C ❑H Irregular Periods
- ❑C ❑H Vaginal Discharge
- ❑ *NONE IN CATEGORY*

Pregnancies:	
Date	Outcome

How do you grade your over all "Quality of Life" ❑ Good ❑ Fair ❑ Poor

How much water do you consume on a daily basis (in ounces):_____

More information regarding the above marked symptoms: _____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize RCC to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance to Kansas' statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Thank you for choosing River City Chiropractic. We look forward to helping you!

Patient Name: _____