Adult Member Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
MARITAL STATUS:	GENDER:
NUMBER OF CHILDREN & AGES:	HEIGHT: WEIGHT:
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ❑ YES # PACK/DAY ❑ NO
DO YOU DRINK ALCOHOL? ❑ YES # DRINKS/MONTH ❑ NO
DO YOU DRINK COFFEE, TEA OR SODA? ❑ YES # CUPS/DAY ❑ NO
DO YOU EXERCISE REGULARLY? ❑ YES # DAYS/WEEK ❑ NO
DO YOU EAT FAST FOOD? ❑ YES # OF MEALS/WEEK_____ ❑ NO
ARE YOU AWARE OF THE EFFECTS OF YOUR DIET ON YOUR OVERALL HEALTH? ❑ YES ❑ NO
WOULD YOU LIKE MORE INFORMATION ON THE EFFECTS OF DIET ON YOUR HEALTH? ❑ YES ❑ NO
DO YOU SLEEP WELL? ❑ YES ❑ NO # OF HOURS/DAY_____
HOW DO YOU SLEEP? ❑ BACK ❑ SIDE ❑ STOMACH
DO YOU WEAR: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

CHIROPRACTIC HISTORY

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): ❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING
HAVE YOU BEEN CHECKED FOR VERTEBRAL SUBLUXATION? ❑ YES ❑ NO ❑ I DON'T KNOW
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❑ YES ❑ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME & APPROXIMATE DATE OF YOUR LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

REASON FOR THIS VISIT: ❑ WELLNESS ❑ PAIN COMPLAINT ❑ AUTO/JOB INJURY ❑ NUTRITION
PLEASE DESCRIBE:
WHAT DATE DID THIS BEGIN?
DID THIS PROBLEM START: ❑ SUDDENLY ❑ GRADUALLY ❑ AFTER AN INJURY
HAS THIS CONCERN: ❑ GOTTEN WORSE ❑ BECOME CONSTANT/CHRONIC ❑ GOTTEN BETTER ❑ COME AND GONE
WHAT MAKES THE PROBLEM BETTER?
WHAT MAKES THE PROBLEM WORSE?
DOES THIS CONCERN INTERFERE WITH: ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES PLEASE EXPLAIN:
PLEASE DESCRIBE THE QUALITY OF THE PAIN (SHARP, DULLY ACHY, ETC.)
DOES THE PAIN RADIATE? ❑ YES ❑ NO TO WHERE?
RATE THE SEVERITY OF THE PAIN (0=NO PAIN, 10=E.R. VISIT):
DOES THE PAIN CHANGE THROUGHOUT THE DAY? ❑ YES ❑ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS COMPLAINT? ❑ YES ❑ NO PRIMARY DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

Ballard Family Chiropractic 14225 E. Rickelman
Effingham, IL 62401

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

ARE YOU AWARE THAT CHIROPRACTORS TREAT A CONDITION CALLED SUBLUXATION?
❑ YES ❑ NO

DID YOU KNOW THAT YOU CAN HAVE A SUBLUXATION WITHOUT EXPERIENCING PAIN?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ YES ❑ NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Please check the type of care desired so that we may be guided by your wishes whenever possible. **PLEASE PICK ONE.**

- ❑ **Relief care:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom or pain.
- ❑ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the type of care for my condition.***

PERSONAL HISTORY

DO YOU HAVE ANY DIAGNOSED DISEASES (HEART DISEASE, DIABETES, ETC.)? ? ❑ YES ❑ NO
PLEASE LIST:

DO YOU HAVE A HISTORY OF CAR ACCIDENTS, BROKEN BONES, FALLS OR OTHER TRAUMAS? ❑ YES ❑ NO
PLEASE LIST:

HAVE YOU HAD ANY SURGERIES? ❑ YES ❑ NO
PLEASE LIST WITH APPROXIMATE DATES:

ARE YOU CURRENTLY EXPERIENCING ANY MAJOR STRESS IN YOUR LIFE OTHERWISE UNLISTED ON THIS FORM? ❑ YES ❑ NO

Many problems and health challenges can start as 'nerve interfe ence' blocking the vital power that operates and heals our body Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or healt challenges you may be having under 'other'.

OTHER SYMPTOMS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

_____

_____

_____

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____ ❑M ❑F ❑S ❑G

DEPRESSION ❑M ❑F ❑S ❑G

DIABETES ❑M ❑F ❑S ❑G

HEART DISEASE ❑M ❑F ❑S ❑G

LIVER DISEASE ❑M ❑F ❑S ❑G

HIGH CHOLESTEROL ❑M ❑F ❑S ❑G

HIGH BLOOD PRESSURE ❑M ❑F ❑S ❑G

LUNG PROBLEMS ❑M ❑F ❑S ❑G

SEIZURES ❑M ❑F ❑S ❑G

NECK PROBLEMS ❑M ❑F ❑S ❑G

BACK PROBLEMS ❑M ❑F ❑S ❑G

SCOLIOSIS ❑M ❑F ❑S ❑G

OSTEOARTHRITIS ❑M ❑F ❑S ❑G

RHEUMATOID ARTHRITIS ❑M ❑F ❑S ❑G

AUTOIMMUNE DISEASES ❑M ❑F ❑S ❑G

OTHER:_____

CURRENT MEDICATIONS

When properly prescribed medications mask the symptoms of disease & contribute to more than 100,000 deaths annually. Please list the medications you take and your dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any supplements you are currently taking:

FEMALE PATIENTS

ARE YOU: ❑ CYCLING MONTHLY ❑ PERIMENOPAUSAL ❑ MENOPAUSAL

ARE YOU CURRENTLY PREGNANT? ? ❑ YES ❑ NO

IF YES, HOW FAR ALONG?_____WEEKS

DUE DATE:_____

ARE YOU CURRENTLY BREASTFEEDING? ? ❑ YES ❑ NO

ARE YOU CURRENTLY USING BIRTH CONTROL? ❑ YES ❑ NO

WHAT TYPE?

DO YOU:

EXPPERIENE PAINFUL PERIODS? ❑ YES ❑ NO

HAVE IRREGULAR CYCLES? ❑ YES ❑ NO

HAVE HEAVY/CLOTTY PERIODS? ❑ YES ❑ NO

HAVE SPOTTING BETWEEN CYCLES? ❑ YES ❑ NO

HAVE PAINFUL OR CRAMPY PERIDS? ❑ YES ❑ NO

EXPERIENCE INFERTILY? ? ❑ YES ❑ NO

PERFORM MONTHLY BREAST EXAMS? ❑ YES ❑ NO

HAVE ANNUAL MAMMOGRAMS? ❑ YES ❑ NO

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS?

1._____

_____

2._____

_____

3._____

_____

IF THERE ARE ANY ISSUES THAT YOU ARE EXPERIENCING, OR THAT YOU HAVE CONCERNS ABOUT THAT HAVE NOT BEEN ADDRESSSED ON THESE FORMS, PLEASE WRITE THEM IN USING THE SPACE BELOW.

THANK YOU FOR CHOOSING BALLARD FAMILY CHIRORPACTIC AND HELPING US CONTINUE OUR MISSION TO ***GROW A HEALTHIER COMMUNITY, ONE FAMILY AT A TIME***!