Adult Health Profile

PATIENT DEMOGRAPHICS

Name: ____ Birthdate: _____-_____-_____

Address: _______________________________________ City: ___________________ State: _____ Zip: ___________

Mobile Phone: _______________________ E-mail Address: __________________________________

Employer: ______________________________________ Occupation:_______________________________________

Number of Children and Ages: ____

Emergency Contact: ____________________ Number: __________________ Relationship: ________________

Primary Care Provider: __________________ Office Name: __________________

DAILY LIFE SUMMARY

Please circle any of the following that describes your typical day:

Sitting 5+ hrs Standing 5+ hrs Physically Demanding Stressful Commuting/Traffic

Circle any that describe your typical work day:

Work from Home Desk Job On your Feet Travel for Work Variable Schedules

Social History:

Smoke: ◯Cigars ◯Pipes ◯Cigarettes ◯Vapes **How Often?** ◯Daily ◯Occasionally ◯Never

Alcoholic Beverages: ◯Daily ◯Occasionally ◯Never

Recreational Drug Use: ◯Daily ◯Occasionally ◯Never

Circle any of the following that your current condition limits:

Lifting Static Standing Static Sitting Driving Electronic Usage Work Walking Sleep Concentration

What progress would make the most impact in your daily life? (*Circle all that apply*)

Less Allergies
Better Mobility
Better Sleep
Increased Activities
Less Numbness in Limbs
Improved Athletic Performance
Less Pain
Less Sick Days
More Energy
Fewer Headaches
Better Digestion
Less Anxiety
Other: ____________________________________

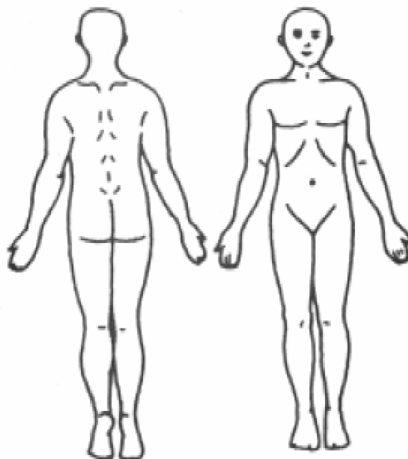
HISTORY OF COMPLAINT

Identify and describe your chief concerns:

Health Concerns Listed According to Severity:	When Did This Problem Begin?	When is it at its Worst? (AM, Mid-day, PM)	Are Symptoms Constant or Intermittent?
Primary: ____________________	____________________	____________	_________________
Second: ____________________	____________________	____________	_________________
Third: ____________________	____________________	____________	_________________
Fourth: ____________________	____________________	____________	_________________

CIRCLE the areas on the body diagram where your concerns are located and MARK with the following letters to describe your symptoms:

R-Radiating
B-Burning
D-Dull
A-Aching
N-Numbness
S-Sharp/**S**tabbing
T-Tingling



What relieves your symptoms? ____

What makes your symptoms worse? ____

Did any of your concerns occur from an accident or injury? ◯Yes- What Happened? ◯No

____

____

Do you take any of the following for your symptoms?

◯Tylenol ◯Ibuprofen ◯Alieve ◯Other _________________

How Often?

◯Daily ◯Weekly ◯Monthly

CIRCLE ALL SENSORY ISSUES YOU HAVE OR HAVE HAD

Headache	Neck Pain	Shoulder Pain	Elbow Pain	Wrist Pain	Hand Pain
Upper Back Pain	Chest Pain	Mid Back Pain	Rib Pain	Low Back Pain	Pelvic Pain
Hip Pain	Knee Pain	Ankle Pain	Foot Pain		

Pain W/ Cough/Sneeze Numbness/Tingling arms, hands, fingers Numbness/Tingling legs, feet, toes

CIRCLE ALL FUNCTIONAL ISSUES YOU HAVE OR HAVE HAD

Trouble Sleeping	Frequent Colds	Chronic Fatigue	Allergies	Anxiety
Heartburn	Dizziness	Balance Issues	Vision Issues	Vertigo
Ear Infections	Ringing in Ears	Hearing Loss	Sinus Issues	Thyroid Issues
Heart Issues	High Blood Pressure	Low Blood Pressure	Lung Issues	Asthma
Liver Disease	Gallbladder Issues	Digestive Issues	Kidney Issues	Bladder Issues
Menstrual Issues	Menopausal Issues	Fertility Issues	Prostate Issues	Depression
Eating Disorder	Mood Changes	ADD/ADHD	Lupus	Fibromyalgia
Other:____________	_______________	_______________	______________	_____________

Additional Health Information

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

Stroke Cancer Heart disease Spinal Surgery Seizures Spinal Bone Fractures Arthritis Diabetes

ANY FAMILY HISTORY OF:

Stroke Cancer Heart disease Spinal Surgery Seizures Arthritis Diabetes

Any other hereditary conditions? ◯Yes ◯No

____

____

List all surgical operations and years:

____

____

List all prescription medications you are taking:

____

____