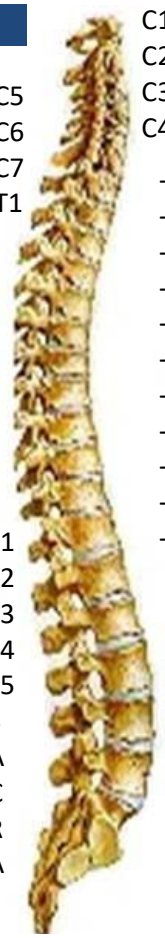
Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please **CIRCLE** below any concerns you are experiencing now as well as in the past. Then please list your **Top Five Health Challenges** even if you think it is something that we can't help with.

Your Concerns



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

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
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

Top Five Health Challenges:

1) _____

2) _____

3) _____

4) _____

5) _____

Health Conditions

Instructions: Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or Frequent Headaches	☐ Thyroid Problems	☐ Pain in Arms/Legs/ Hands	☐ Numbness	For Women Only:
☐ Heart Surgery/ Pacemaker	☐ Sinus Problems	☐ Low Blood Pressure	☐ Allergies	Are you Pregnant? Yes No
☐ Lower Back Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ Diabetes	If Yes, When is your due date?
☐ Digestive Problems	☐ Difficulty Breathing	☐ Ulcers/Colitis	☐ Surgeries	Are you nursing? Yes No
☐ Pain Between shoulders	☐ Kidney Problems	☐ Tuberculosis	☐ Asthma	Are you taking Birth Control Yes No
☐ Congenital Heart Defect	☐ High Blood Pressure	☐ Arthritis	☐ Loss of Sleep	Do You: Experience Painful Periods?: Yes No
☐ Frequent Neck Pain	☐ Chemotherapy	☐ Shingles	☐ Dizziness	Have Irregular Cycles?: Yes No
				Have Breast Implants: Yes No

☐ Surgeries: (Please list all surgeries you have had)

Mediapolis Natural Health

Adult Health Record

About You

Name:	
Address:	
City:	State/Zip Code:
Home Phone:	Cell Phone:
Email Address:	
Date of Birth:	Age:
Social Security Number:	Gender:
Marital Status:	Number of Children:
Employer:	
Work Phone:	Position Title:

Chiropractic Experience

Who Referred you to our office?
How did you hear about our office? (Circle) Newspaper Sign Google Facebook Healthcare Provider:
Have you been adjusted by a Chiropractor before? (Circle) YES NO
Chiropractor's Name:
Approximate date of last adjustment?

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Demographics

Preferred Language:
Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer
Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latina / Decline to Answer

Health Habits

Smoking Status? (Circle One)	Every Day Smoker Occasional Smoker Former Smoker Never Smoked
Do you Drink Alcohol? (Circle)	YES NO
Do You Drink Coffee, Tea or Soda? (Circle)	YES NO
Do You Exercise Regularly? (Circle)	YES NO

REASON FOR THIS VISIT

Describe the reason for this visit?
Briefly describe the impact your current concern has had on your life. (Circle all that apply) Work Sleep Family Daily Routine Hobbies Other:
When did this concern begin?
Has this Concern: (Circle one) Gotten worse Stayed the same Gotten better
Has this concern occurred before? (Circle) YES NO
Have you seen other doctors for this concern? YES NO
Type of Treatment: Doctors Name:
Results: GOOD BAD INDIFFERENT

Medications and Dosage

Medication Allergy / Date of Onset
