ADULT HEALTH APPRAISAL QUESTIONNAIRE

Complete this form to the best of your ability.
If you have current lab results (SMA, CBC/with diff or Thyroid work T3, T4, T7, TSH)
or other information you feel would be helpful, please attach

Today's Date _____

Date of Birth _____ Occupation _____

Name _____

Address _____ Telephone Home ___ - ___ - _____

City _____ Work ___ - ___ - _____

State _____ Zip Code _____ Fax ___ - ___ - _____

Country _____ E-mail _____

Employment Status

school mother work full time part time unemployed disabled retired

Living situation alone parents spouse friend(s) boarding

Marital status never married now married divorced widowed

Medical Insurance _____ Agent _____

Address _____ Phone _____

ID Number _____ Soc Sec _____

Person to be contacted in case of emergency _____

Address _____ Phone _____

Members of Household:

Name	Age	Relationship

Are you a NACD family? yes/no If yes, who did your last evaluation? _____ Location _____

Are you allergic to any drugs (penicillin, etc.)? yes/no _____

_____

Any other allergies? _____

_____

Do you have any housing problems? (heating, rats, roaches, paint peeling) yes/no _____

_____

Do you have worrisome financial problems? yes/no _____

Have you been hospitalized recently? yes/no _____ More than three times? yes/no _____

Give the following information for the last times you have been hospitalized starting with the most recent (except normal pregnancies)

	Hospitalization (1)	Hospitalization (2)	Hospitalization (3)
Type of operation or illness			
Month and year hospitalized			
Name of hospital			
City and State			

MEDICAL HISTORY

Print the names of your relatives, living or dead, in the list below. Place a (√) in the appropriate column for any illnesses that you or the relatives listed at the left have had.

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	Allergies	Anemia	Anorexia	Arthritis/Gout	Asthma	Bleeding/Bruising Problems	Bulemic	Cancer or Tumors	Convulsions/Epilepsy	Diabetes	Drinking or Drug Problems	Eczema	Emphysema	Gallstones	Heart Trouble	Hepatitis	High Blood Pressure	Frequent Infections	Kidney or Bladder Problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Weight Problems
Your Illnesses																																		
Father																																		
Mother																																		
Brothers/ Sisters																																		
Children																																		
Grandparents																																		

Do you use: Yes Amount

Coffee _____

Cigarettes _____

Alcohol _____

Aspirin _____

Birth Control Pills _____

Sedatives/Tranquilizers _____

Thyroid _____

Laxatives _____

Cortisone _____

Hormones _____

Drugs:

_____

_____

_____

Medicinal Herbs, teas, vitamins:

_____

_____

_____

_____

_____

_____

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If you have had any of the following tests or immunizations place a √ in the appropriate box and, if you can, give the year you last had them.

Year	Tests	Year	Immunizations	Adverse Reactions
_____	Chest x-ray	_____	Smallpox	_____
_____	Kidney x-ray (I.V.P.)	_____	Tetanus	_____
_____	G.I. series	_____	Polio	_____
_____	Colon x-ray (barium enema)	_____	Typhoid	_____
_____	Gallbladder x-ray (Cholecystagnam)	_____	Flu	_____
_____	Electrocardiogram	_____	Mumps	_____
_____	T.B. text	_____	Measles	_____
_____	Other x-rays	_____	Other	_____

Have you had any of the following as an adult or during childhood:

High Fever
Severe Flu
Blood transfusion reaction
Injury requiring stitches
Fractures (explain) _____

Car accident(s) date(s): _____
Any skin conditions treated by a dermatologist or Podiatrist (explain) _____
_____
_____

Any prolonged illness (Please describe) _____

Work exposure to chemicals or fumes (please describe) _____

Have you ever had Chiropractic care? Date of last treatment _____

DIET

Typical breakfast _____

_____

Snack _____

Typical lunch _____

_____

Snack _____

Typical dinner _____

_____

Snack _____

Do you crave certain foods? _____

Do certain foods "disagree" with you? _____

_____

How many glasses of water a day do you drink? _____

Please list the main complaints you have _____

_____

_____

WOMEN

Date of last normal menstrual period _____ Period occurs every _____ days.

Amount of flow _____ Duration _____ Regular _____Cramps _____

Birth control methods if applicable _____

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Yes No

- frequent or severe headaches
- neck pains
- neck lumps or swelling
- loss of balance
- dizzy spells
- blackouts/fainting
- wear glasses
- blurry vision
- eyesight worsening
- see double
- see halos or lights
- eye pains or itching
- watering eyes

- hearing difficulties
- earaches
- running ears
- noises in ears

- dental problems
- sore or bleeding bums
- sore tongue

- congested nose
- running nose
- sneezing spells
- head colds
- nosebleeds
- sore throat
- difficulty swallowing
- hoarse voice

- wheezing or gasping
- frequent coughing
- cough up phlegm
- cough up blood
- chest colds

- rapid or skipped heartbeats
- shortness of breath with normal activity
- swollen fee or ankles
- shortness of breath with ascending steps or hill

- recurring indigestion
- frequent belching
- nausea

Yes No

- vomiting
- pain in abdomen
- bloated abdomen
- constipation
- loose bowels
- black stools
- grey or whitish stools
- pain in rectum
- itching rectum
- blood with stools
- symptoms if miss or late for a meal i.e. irritability, weakness, etc.

- frequent urination
- involuntary escape of urine
- burning on urination
- brown, lack or bloody urine
- weak urine stream
- difficulty starting urine
- constant urge to urinate

- aching muscles or joints
- swollen joints
- back or should pains
- weakness in arms or legs
- painful feet
- trembling
- numbness
- leg cramps

- skin problems
- scalp problems
- itching or burning skin
- bruises easily

- nervousness or anxiety
- nervous with strangers
- nail biting
- difficulty making decisions
- lack of concentration
- absentminded/loss of memory
- lonely or depressed
- frequent crying
- hopeless outlook
- difficulty relaxing
- worry a lot
- frightening dreams or thoughts

Yes No

- feeling of depression
- shy or sensitive
- dislike criticism
- angered easily
- annoyed by little things
- family problems
- problems at work
- sexual difficulties
- changes of sexual energy
- considered suicide
- sought psychiatric help

- loss or gain in weight
- frequently feel warmer or colder than others
- loss of appetite
- always hungry
- armpits or groin swelling
- unusual fatigue or weariness
- difficulty sleeping
- fever or chills
- motion sickness
- excessive sweating
- night sweats
- hot flashes

MEN ONLY

- burning or discharge
- lumps or swelling on testicles
- painful testicles

WOMEN ONLY

- a missed period
- menstrual problems
- bleeding between periods
- tonation of pain before periods
- heavy bleeding
- bearing down feeling
- vaginal discharge
- genital irritation
- pain on intercourse
- swelling or lumps in breasts
- painful breasts

____ number of pregnancies
____ number of births
____ miscarriages
____ premature births
____ caesareans
____ abortions

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Have you ever experienced an emotional, spiritual or physical incident from which you feel you have never recovered your previous level of health? (discuss briefly): _____

_____

_____

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