BODY ELEMENTS CHIROPRACTIC AT ENCORE
believe in better!
believe you deserve it!
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bodyelementspdx.com
bodyelementspdx.com

Adult Health History

Name: Date of Birth: Today's Date:

Your purpose today for visiting this office today is:
☐ Temporary pain reduction ☐Corrective care ☐Wellness care ☐Manual Chiropractic adjustments
☐Bio Energetic Synchronization (B.E.S.T.) ☐Nutrition Response Therapy (NRT) ☐KST
☐ArthroStim ☐Activator ☐Other:

Chief Complaint Information- Room for only two, if there is more, we'll go in to more details

Primary chief complaint – one issue at the time please.

1- Primary complaint / issue?

2- Have you experience this before? ☐ Yes ☐ No

3- How did it start? ☐Sudden ☐ Gradual ☐Other:

4- When did it start?

5- What makes it worse?

6- What makes it better?

7- Have you seen anyone else for this? ☐ Yes ☐ No
7a- If yes, who and was it helpful?

8- Any radiation of symptoms? ☐ Yes ☐ No
8a- If yes, to where?

9- Is it: ☐Achy ☐Sharp ☐Numb / Tingling ☐Deep ☐Burning ☐ Other: _____

10- Is this worst at: ☐ Morning ☐Noon ☐ Afternoon ☐ Evening ☐ Night ☐Other: _____

11- The symptom effected when you: ☐Sit ☐ Sleep ☐Walk ☐Standup ☐Bend ☐ Move ☐ Other:

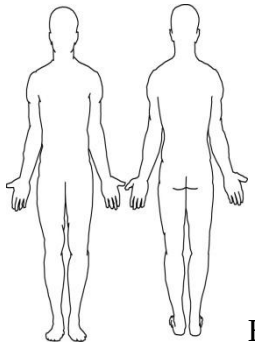
12- How often? ☐ Daily ☐Weekly ☐ Monthly ☐ Constant ☐ Other: _____

13- % of time you experience this? ☐%10☐%20☐%30☐%40☐%50☐%60☐%70☐%80☐%90☐%100

14- Have you tried: ☐Hot ☐Cold ☐ Meds ☐Nothing ☐Other
14a- If using meds, please list

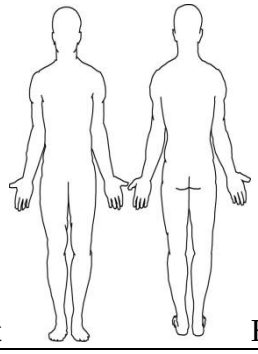
15-Do you consider this to be serious? ☐ Yes ☐ No

Please mark the location of discomfort on the left.
Please put a number from
0----------10
(no pain) - (most imaginable pain)
next to the location of discomfort.



Front Back

Secondary complaint – one issue at the time please.
1-Secondary complaint / issue?
2- Have you experience this before? ☐ Yes ☐ No
3- How did it start? ☐Sudden ☐ Gradual ☐Other:
4- When did it start?
5- What makes it worse?
6- What makes it better?
7- Have you seen anyone else for this? ☐ Yes ☐ No 7a- If yes, who and was it helpful?
8- Any radiation of symptoms? ☐ Yes ☐ No 8a- If yes, to where?
9- Is it: ☐Achy ☐Sharp ☐Numb / Tingling ☐Deep ☐Burning ☐ Other: _____
10- Is this worst at: ☐ Morning ☐Noon ☐ Afternoon ☐ Evening ☐ Night ☐Other: _____
11- The symptom effected when you: ☐Sit ☐ Sleep ☐Walk ☐Standup ☐Bend ☐ Move ☐ Other:
12- How often? ☐ Daily ☐Weekly ☐ Monthly ☐ Constant ☐ Other: _____
13- % of time you experience this? ☐%10☐%20☐%30☐%40☐%50☐%60☐%70☐%80☐%90☐%100
14- Have you tried: ☐Hot ☐Cold ☐ Meds ☐Nothing ☐Other 14a- If using meds, please list
15-Do you consider this to be serious? ☐ Yes ☐ No

Please mark the location of discomfort on the left. Please put a number from 0----------10 (no pain) - (most imaginable pain) next to the location of discomfort.	 Front Back

If there are more issues you would like addressed, please write here:

Lifestyle questions – You may be brief we'll go into more details if necessary

1-Were you on any medication for a prolonged amount of time? ☐Yes ☐No
1a – If yes, what, why and for how long?

2-Are you currently taking medication(s)? ☐Yes ☐No
2a - If yes, what and for what purpose?

3-Do you take: ☐Vitamin D? ☐Probiotics? ☐Fish oil? ☐Multivitamin?

4- List any other supplements if any:

5-Have you ever been hospitalized? ☐Yes ☐No
5a-If yes, why?

6-Have you ever surgeries? ☐Yes ☐No
6a-If yes where on your body and why?

7-Have you had any major accidents/falls? ☐Yes☐No
7a-If yes, please explain;

8-Do / did you have any fractures? ☐Yes ☐No
8a-If yes, where?

9-Do you have any scars? ☐Yes ☐No
9a-If yes, where?

10-Do you have any Mercury fillings? ☐Yes ☐No	11-Do you have any root canals? ☐Yes ☐No
12-Are you vegetarian? ☐Yes ☐No	13-Are you vegan? ☐Yes ☐No

14-How often do you consume;

- Fruit? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Vegetables? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Protein? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Dairy? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Soda? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Coffee /caffeine? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Alcohol? ☐ In the past ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Cigarettes? ☐ In the past ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Rec. drugs? ☐ In the past ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day

Lifestyle questions – You may be brief we'll go into more details if necessary

15-Do you have any allergies? ☐Yes ☐No
15a-If yes, to what?

16- How often do you exercise? ☐Never ☐Once in a while ☐Weekly ☐Daily ☐Multiple times per day

17- How much water do you consume on average, daily? _____ ☐Glasses ☐Ounces

18- Are you healthier now than you were 5 years ago? ☐Yes ☐No

19- When do you generally feel your best? ☐AM ☐PM

20- When do you generally feel your worst? ☐AM ☐PM

21- How committed to your health are you? ☐Not at all ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10☐ Extremely

22- How important is your health to you? ☐Not at all ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10☐ Extremely

23- Do you think your health is: ☐Challenged ☐Fair ☐Good ☐Very Good ☐Excellent

24- Would you like your health to be ☐Challenged ☐Fair ☐Good ☐Very Good ☐Excellent

Systems Review- check "P" for past and "C" for current, where applicable, use R for right and "L" for left or circle where appropriate

1- Have you had or do you now have any of the following *pulmonary (lung related)* issues?

1a- Asthma: ☐P ☐C	1b- Difficulty breathing: ☐P ☐C
1c- COPD: ☐P ☐C	1d- Emphysema: ☐P ☐C
1e- None: ☐	1f- Other:

2- Have you had or do you now have any of the following related *cardio vascular (heart)* issues?

2a- Heart surgery: ☐P ☐C	2b- Congestive heart filature: ☐P ☐C
2c-Heart attacks: ☐P ☐C	2d- Atrial fibrillation: ☐P ☐C
2e-Angina / chest pain: ☐P ☐C	2f- Irregular heart beat: ☐P ☐C
2g- Pacemaker: ☐P ☐C	2h- Hyper tension: ☐P ☐C
2i- Stroke: ☐P ☐C	2j- Blood thick / thin: ☐P ☐C
2k- None: ☐	2l- Other:

3- Have you had or do you now have any of the following *neurologic (nerve related)* issues?

3a- Visual changes / loss of vision: ☐P ☐C	3b- Seizures: ☐P ☐C
3c- One sided weakness of face: ☐P ☐C	3d- One sided weakness of body: ☐P ☐C
3e- One sided decrease of sensation in face: ☐P ☐C	3f- One sided decrease of sensation in body: ☐P ☐C
3g- Headaches: ☐P ☐C	3h- Memory loss: ☐P ☐C
3i- Tremors: ☐P ☐C	3j- Loss of sense of smell: ☐P ☐C
3k- Stroke: ☐P ☐C	3l- Vertigo: ☐P ☐C
3m- None: ☐	3n- Other:

Systems Review- **check "P" for past and "C" for current, where applicable, use R for right and "L" for left or circle where appropriate**

4- Have you had or do you now have any of the following *endocrine (glandular / hormonal related)* issues or procedure?

4a- Thyroid disease: ☐P ☐C	4b- Hormone replacement therapy: ☐P ☐C
4c- Inject-able steroid replacement: ☐P ☐C	4d- Gland removal:
4e- Diabetes type I: ☐P ☐C	4f- Diabetes type II: ☐P ☐C
4g- None: ☐	4h- Other:

5- Have you had or do you now have any of the following *renal (kidney related)* issues?

5a- Incontinences (can't control) : ☐P ☐C	5b- Renal / calculi stones: ☐P ☐C
5c- Hematuria (blood in urine) : ☐P ☐C	5d- Hematochezia (blood through rectum) : ☐P ☐C
5e- Bladder infection: ☐P ☐C	5f- Difficulty urinating: ☐P ☐C
5g- Kidney disease: ☐P ☐C	5h- Dialyses: ☐P ☐C
5i- None: ☐	5j- Other:

6- Have you had or do you now have any of the following gastro intestinal (stomach / digestion related) issues?

6a- Nausea: ☐P ☐C	6b- Difficulty swallowing: ☐P ☐C
6c- Ulcerative colitis: ☐P ☐C	6d- Frequent abdominal pain: ☐P ☐C
6e- Hiatal hernia: ☐P ☐C	6f- Constipation: ☐P ☐C
6g- Diarrhea: ☐P ☐C	6h- Pancreatic disease: ☐P ☐C
6i- Irritable bowel / colitis: ☐P ☐C	6j- Hepatitis / liver disease: ☐P ☐C
6k- Vomiting blood: ☐P ☐C	6l- Black or tarry stool: ☐P ☐C
6m- Bowel incontinent: ☐P ☐C	6n- Gastroesophageal reflux / heart burn: ☐P ☐C
6o- None: ☐	6p- Other:

7- Have you had or do you now have any of the following *dermatological (skin related)* issues?

7a- Significant burns: ☐P ☐C	7b- Significant rashes: ☐P ☐C
7c- Significant Acne: ☐P ☐C	7d- Psoriatic disorder: ☐P ☐C
7e- Eczema: ☐P ☐C	7f- Melanoma: ☐P ☐C
7g- Excessive moles: ☐P ☐C	7h- Excessive skin tags: ☐P ☐C
7i- None: ☐	7j- Other:

8- Have you had or do you now have any *musculoskeletal (bone / muscle related)* issues?

8a- Rheumatoid arthritis: ☐P ☐C	8b- Gout: ☐P ☐C
8c- Osteoarthritis: ☐P ☐C	8d- Spinal fracture: ☐P ☐C
8e- Excessive Arthritis (unknown type): ☐P ☐C	8f- Spinal surgery: ☐P ☐C
8g- Scoliosis: ☐P ☐C	8h- Metal implants: ☐P ☐C
8i- None: ☐	8j- Other:

Systems Review- check "P" for past and "C" for current, where applicable, use R for right and "L" for left or circle where appropriate

9- Have you had or do you now have any of the following *psychological issues*?

9a- Psychiatric diagnosis: ☐P ☐C	9b- Depression: ☐P ☐C
9c- Suicidal ideation: ☐P ☐C	9d- Bipolar disorder: ☐P ☐C
9e- Homicidal ideation: ☐P ☐C	9f- Schizophrenia: ☐P ☐C
9g- Psychiatric hospitalization: ☐P ☐C	9h- Anxiety: ☐P ☐C
9i- None: ☐	9j- Other:

10- Have you had or do you have any of the following *symptoms / pain / discomfort*?

10a- Head ache: ☐P ☐C - ☐R ☐L	10b- Face: ☐P ☐C - ☐R ☐L
10c- Sinus issues: ☐P ☐C - ☐R ☐L	10d- Jaw: ☐P ☐C - ☐R ☐L
10e- Neck: ☐P ☐C - ☐R ☐L	10f- Throat: ☐P ☐C - ☐R ☐L
10g- Upper back: ☐P ☐C - ☐R ☐L	10h- Middle back : ☐P ☐C - ☐R ☐L
10i- Lower back: ☐P ☐C - ☐R ☐L	10j- Sacrum: ☐P ☐C - ☐R ☐L
10k- Coccyx: ☐P ☐C - ☐R ☐L	10l- Pubic symphysis: ☐P ☐C - ☐R ☐L
10m- Hip: ☐P ☐C - ☐R ☐L	10n- Knee: ☐P ☐C - ☐R ☐L
10o- Ankle: ☐P ☐C - ☐R ☐L	10p- Foot: ☐P ☐C - ☐R ☐L
10q-Shoulder: ☐P ☐C - ☐R ☐L	10r- Elbow: ☐P ☐C - ☐R ☐L
10s-Wrist: ☐P ☐C - ☐R ☐L	10t- Hand: ☐P ☐C - ☐R ☐L
10u-Rib: ☐P ☐C - ☐R ☐L	10v- Clavicle / Sternum: ☐P ☐C - ☐R ☐L
10w- None: ☐	10x- Other:

Circle M for mother and / or F for father where / if applicable.			
Diabetes:	☐ Mother ☐ Father ☐ Sibling	Heart Disease:	☐ Mother ☐ Father ☐ Sibling
High Blood Pressure:	☐ Mother ☐ Father ☐ Sibling	Rheumatoid Arthritis:	☐ Mother ☐ Father ☐ Sibling
Lupus :	☐ Mother ☐ Father ☐ Sibling	Cancer:	☐ Mother ☐ Father ☐ Sibling
Other:	☐ Mother ☐ Father ☐ Sibling	Other:	☐ Mother ☐ Father ☐ Sibling

Previous Chiropractic Experience
Have you ever been to a Chiropractor before? ☐Yes ☐No
If yes, what was the reason for your visit?
You previous experience was; ☐ Excellent ☐ Good ☐ Beneficial ☐ Bad Other: _____
When was your last physical?
When was your last X-ray?
Positive findings?

FEMALE ONLY! PLEASE

Are you currently pregnant? ☐Yes ☐No	If yes, how far along?
What method of birth control do you use? ☐Abstinence ☐Pill ☐IUD ☐ Patch ☐Other: _____	
Do you have any biological children? ☐Yes ☐No	Were they; ☐Vaginal ☐C-section
Do you have episiotomy scars? ☐Yes ☐No	Are your cycles regular? ☐Yes ☐No

Please check yes or no or use your own words	
Do you have confidence and a compassionate view of yourself?	☐Yes ☐No
Are you open to new ideas?	☐Yes ☐No
Do you like what you do for a living?	☐Yes ☐No
Do you enjoy a sense of purpose and peace in your life?	☐Yes ☐No
Are addictions a challenge for you?	☐Yes ☐No
Do you invite constant and never ending improvement in your life?	☐Yes ☐No
Do you sleep well at night and awake rested?	☐Yes ☐No
Do you awake frequently at night to urinate?	☐Yes ☐No
Do you have a sustained energy throughout the day?	☐Yes ☐No
What emotion(s) best describes you?	

Is there anything else you would like to comment on today?

What goals would you like to achieve while under care in this office?

Signature and name: _____ Date: _____

Your health is your greatest asset. Thank you for the opportunity to serve you!

OFFICE USE ONLY	
PT: ☐DR ☐EX ☐AM ☐AN	VO:☐ TPR ☐CC ☐WC
G/WF:	

Marina Zaré, DC^{+} _____ Date: _____