Gabbert Chiropractic

Dr. Tracy L. Gabbert
Chiropractor
www.glendivechiropractor.com

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:

❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

PLEASE LIST YOUR CHILDREN'S NAMES & AGES

NAME:	AGE:	NAME:	AGE:
NAME:	AGE:	NAME:	AGE:
NAME:	AGE:	NAME:	AGE:

EMPLOYER NAME:	
WORK PHONE:	OCCUPATION:

PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD

ABOUT YOUR SPOUSE

SPOUSE NAME:

SPOUSE EMPLOYER:

POSITION TITLE:

HEALTH HABITS

DO/DID YOU SMOKE? ❑ YES ❑ NO If yes, how much per day_____

DO/DID YOU DRINK ALCOHOL? ❑ YES ❑ NO If yes, how much per week_____

DO YOU DRINK COFFEE, TEA, OR SODA ❑ YES ❑ NO If yes, how much per day_____

DO YOU EXERCISE REGULARLY? ❑ YES ❑ NO

DO YOU WEAR:

❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

DO YOU GET RESTFUL SLEEP? ❑ YES ❑ NO
HOW MANY HOURS PER NIGHT? _____

DO YOU TAKE A DAILY VITAMIN OR SUPPLEMENT? ❑ YES ❑ NO

CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

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 LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ WELLNESS ❑ CHRONIC DISCOMFORT ❑ HOME INJURY ❑ FALL
❑ SPORTS ❑ WORKERS COMPENSATION ❑ OTHER
PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?
❑ YES ❑ NO ❑ N/A

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVE SYSTEM? ❑ YES ❑ NO
THE NERVE SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❑ YES ❑ NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ 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 the body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

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

Would you like to know more about:

- ❑ Proper nutrition, meal planning, vitamins and supplements
- ❑ Proper exercise routines and techniques
- ❑ How to deal with lifestyle stress

MEDICATIONS YOU TAKE

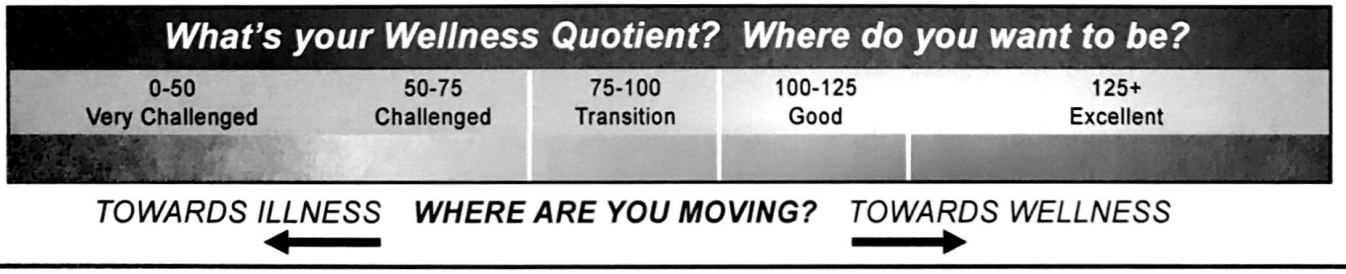
❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICINE
❑ ANTI-DEPRESSANT	❑ BLOOD THINNERS
❑ SLEEP AID	❑ PAIN KILLERS AND ASPRIN
❑ MUSCLE RELAXERS	❑ OTHER:
❑ INSULIN	❑ OTHER:

HEALTH CONDITIONS

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have 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.*

❑ SLEEPING PROBLEMS	❑ DIZZINESS	❑ INFERTILITY	❑ FATIGUE	**FOR WOMEN ONLY:**
❑ NUMBNESS/TINGLING	❑ DEPRESSION	❑ ANXIETY	❑ ALLERGIES	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOW BACK PAIN	❑ NECK PAIN	❑ MID BACK PAIN	❑ HEADACHES	IF YES WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ ULCERS/COLITIS	❑ IRRITABILITY	❑ DIABETES	ARE YOU NURSING? ❑ YES ❑ NO
❑ BREATHING PROBLEMS	❑ COLD HANDS/FEET	❑ HOT FLASHES	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ SINUS PROBLEMS	❑ ARTHRITIS	❑ HEARTBURN	❑ CONSTIPATION	*DO YOU:*
❑ MENSTRUAL PAIN/ IRREGULARITY	❑ HIGH BLOOD PRESSURE	❑ OTHER _____	❑ OTHER _____	EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO

Your Wellness Quotient is a number on a scale from 0-200 and is based on your current lifestyle choices-how and what you are eating, your sleep and exercise habits, etc. **INSTRUCTIONS:** *On the chart below, mark an "x" where you think your current Wellness Quotient is and mark an "O" where you want to be.*



The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Print Name _____ Signature _____ Date _____

Gabbert Chiropractic
115 South Kendrick Ave.
Glendive, MT 59330
(406) 377-2101
doctort@midrivers.com