SCOTT S. SARDONICUS, DC

215 BROWNS RIDGE RD | OSSIPEE NH 03864

ADULT RE-ENTRY HISTORY

Name: _____ Date: _____

Please fill out the following for anything new or different since your last visit.

Are you here for: ☐ a wellness checkup ☐ a specific concern

Present health concerns	How often	Duration	Severity (1-10)

Rate your ability to perform your normal activities (work, play, sports, housework, driving, sitting, walking, sleeping etc)

UNABLE [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] AWESOME

Describe any limitations: _____

Have you been under chiropractic care in any other office since your last visit here? ☐ No ☐ Yes

Date of last visit: _____ About how many adjustments were given? ____ Chiropractor's Name: _____

Are you currently under the care of any other health care provider? (ie medical doctor, physical therapist, naturopath, acupuncturist, massage therapist etc) Please list name, reason for care, results:

Please list any traumas or major life events since you were last a patient in this office:

What changes in your health would you like to see?

Is now a good time to commit to cultivating these changes? ☐ Yes ☐ No

Are you currently taking any prescription drugs, herbs, vitamins, supplements or homeopathic remedies? If so, please indicate reason, how much, results:

What do you do for exercise and how often? (ie walking, running, biking, weight training, swimming, yoga etc)

What do you do for stress management and how often? (ie meditate, yoga, gardening, reading, listen to music, sports etc)

How would you rate your level of stress: NONE 1 2 3 4 5 6 7 8 9 10 HIGH

Explain what causes your stress? (ie health, family issues, work etc)

Please circle Yes or No as the following applies to you. Indicate how much and how often.

Do you drink water	Y N		Red meat	Y N		White sugar	Y N	
Whole grains	Y N		Fruit juice	Y N		Soda	Y N	
Fresh vegetables	Y N		Sweets	Y N		Alcohol	Y N	
Salad/raw veggies	Y N		Dairy products	Y N		Tobacco	Y N	
Fresh fruit	Y N		Junk food	Y N		Coffee	Y N	
Seafood	Y N							

Are there any dietary improvements that you would like to make or are currently working on?

How many hours of sleep do you get each night? ____ Is it enough? Y N If no, indicate why?

Additional comments/concerns: