

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS #:	DOB:	Sex: <input type="radio"/> M <input type="radio"/> F
Marital Status:	# of Children:	Occupation:
Street Address:	Height:	
City, State, Zip:	Weight:	
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No - If yes, please name them and their specialty:		
Please note any significant family medical history:		

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Have you received care for this problem before? ☐ Yes ☐ No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

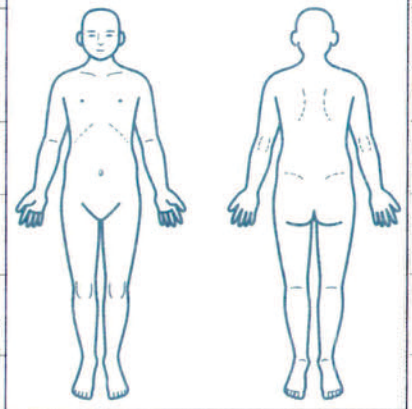
What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X= Current condition

O= Past condition



YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ☐ Resolve existing condition(s) ☐ Overall wellness ☐ Both

Have you ever visited a chiropractor? ☐ Yes ☐ No If yes, what is their name?

What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation-based ☐ Other: _____

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ☐ Yes ☐ No

- If yes, please explain:

Notable childhood injuries? ☐ Yes ☐ No If yes, please explain:

Youth or college sports? ☐ Yes ☐ No If yes, list major injuries:

Any auto accidents? ☐ Yes ☐ No If yes, please explain:

Exercise Frequency? ☐ None ☐ 1-2x per week ☐ 3-6x per week ☐ Daily

What types of exercise?

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach Do you wake up: ☐ Refreshed and ready ☐ Stiff and tired

Do you commute to work? ☐ Yes ☐ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None						None				
	Moderate						Moderate				
	High						High				
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar & Sweets	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None						None				
	Moderate						Moderate				
	High						High				
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGMENT & CONSENT

Patient Name: _____ Date: _____