Softwave QUESTIONNAIRE

CONFIDENTIAL PATIENT INFORMATION

First Name: | Last Name: | Today's Date:

DOB: | Sex: | Marital Status: | # of Children:

Street Address: | City: | State:

Zipcode: | Phone: | Email:

Height: | Weight: | Occupation:

Emergency Contact Name: | Emergency Contact Relation: | Emergency Contact Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit?

Are you receiving care from any other health professionals? ☐ YES ☐ NO

If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition brings you into our office?

Have you received care for this problem before?
If yes, please explain: Ex: Chiropractic Care, Physical Therapy, Home Remedies

When did the condition first begin?

How did the condition start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

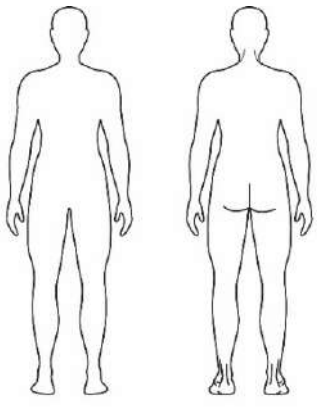
Is this condition: ◯ Getting Worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes this condition better?

What makes this condition worse?

Please indicate where you are experiencing pain or discomfort.

X= current condition O= past condition



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YOUR HEALTH GOALS

What are your top three goals you would like to see accomplished with SoftWave? *Ex: reduction in pain, increase in range of motion*

1. _____

2. _____

3. _____

TRAUMA HISTORY

Have you ever had any significant falls, surgeries, or orther injuries as an adult? If yes, please explain.
Have you had any notable childhood injuries? If yes, please explain.
Did you play any youth or college sports? If yes, list any major injuries.
Any past auto accidents? If yes, please explain.
How often do you exercise? What types of exercise?
Do you normally sleep on your back, side, or stomach? And do you usually wake up refreshed and ready or stiff and tired?
Do you commute to work? If yes, how many minutes per day?
List any problems with flexibility (ex: putting on shoes/socks, etc):
How many hours/day do you typically spend sitting at a desk? How many hours/day do you spend on a computer/tablet/phone?

TOXINS: Chemical & Environmental Exposure

Please rate your consumption for each:

	None		Moderate		High		None		Moderate		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	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 or other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your stress for each:

	None		Moderate		High		None		Moderate		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

Signature: _____ Date: _____

INNATE HEALTH CHIROPRACTIC
SoftWave Tissue Regeneration Technologies

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