Thoughts: Emotional Stresses & Challenges

Please rate/circle your STRESS for each

	None		Moderate			High
Home	0	1	2	3	4	5
Work	0	1	2	3	4	5
Life	0	1	2	3	4	5
Health	0	1	2	3	4	5
Family	0	1	2	3	4	5

Toxins: Chemical & Environmental Exposure

Please rate/circle your CONSUMPTION for each

	None		Moderate			High
Alcohol	0	1	2	3	4	5
Water	0	1	2	3	4	5
Sugar/Sweets	0	1	2	3	4	5
Cigarettes	0	1	2	3	4	5
Gluten	0	1	2	3	4	5
Processed Food	0	1	2	3	4	5
Artificial Sweetners	0	1	2	3	4	5
Dairy	0	1	2	3	4	5
Recreational Drugs	0	1	2	3	4	5
Sugary Drinks	0	1	2	3	4	5

ACKNOWLEDGMENT & CONSENT

Patient Name_____**Date**_____

Would you like to receive Appointment Text Reminders? _____Yes _____No

Cell Phone Provider_____ Cell Phone Number _____

_____2 Hours Beforehand _____4 Hours Beforehand _____1 Day Ahead

Adult Patient Confidential Questionnaire

First Name_____ Last Name_____ Date_____

DOB _____Age_____ Sex ◯ M ◯ F

Marital Status_____ # of Kids _____ Are you pregnant?_____

Occupation_____ Emergency Contact & Phone_____

Street Address_____ Height_____

City, State, Zip _____ Weight_____

Email_____Cell_____ Other Ph._____

How did you hear about us _____

Current Health Conditions

What health conditions bring you to our office? _____

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

When did this begin?_____

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

What makes the problem better?_____

What makes the problem worse? _____

Your Health Goals

Your Top THREE Health/Life Goals

1)_____

2)_____

3)_____

Chiropractic History

What would you like to gain? ◯Resolve existing condition(s) ◯Overall wellness ◯Both

Have you ever been to a chiropractor? ◯Yes ◯No When?_____

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

Traumas

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

If yes, please expain_____

Notable childhood injuries? ◯Yes ◯No Youth/College Sports ◯Yes ◯No

Any auto accidents? ◯Yes ◯No

Exercise? ◯None ◯1-2x per week ◯2-6x per week ◯Daily

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

Do you commute? ◯Yes ◯No

List any problems with flexibility _____

How many hours do you typically sit at a desk, computer, phone? _____

TURN OVER