## Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATI	ON			
First Name:	Last Name:			Date:
SS#:	DOB:		Sex: OM OF	
Marital Status:	# of Children:		Occupation:	
Street Address:			Height: ft.	in.
City:	State:	Zip:	Weight: lbs.	
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?  Yes 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	?		Please indicate	e where you are
				in or discomfort.
Have you received care for this problem before?	Yes No			$\langle \rangle$
- If yes, please explain:				
				$I \cap I \cap I$
When did the condition(s) first begin?				
When did the condition(s) first begin?  How did the problem start? Suddenly Gra	adually OPost-Injury			
_		<b>)</b> Unsure		
How did the problem start? Suddenly Gra		Unsure		
How did the problem start? Suddenly Gralls this condition: Getting worse Improving		) Unsure		
How did the problem start? Suddenly Gralls this condition: Getting worse Improving What makes the problem better?		) Unsure		
How did the problem start? Suddenly Gradents Is this condition: Getting worse Improving What makes the problem better?  What makes the problem worse?		Unsure	To the state of th	
How did the problem start? Suddenly Gralls this condition: Getting worse Improving What makes the problem better?  What makes the problem worse?  YOUR HEALTH GOALS		) Unsure		
How did the problem start? Suddenly Gralls this condition: Getting worse Improving What makes the problem better?  What makes the problem worse?  YOUR HEALTH GOALS		Unsure		

CHIROPRAC	TIC HIS	TORY										
What would you	u like to gai	n from c	hiropractic	care?(	Resolve e	xisting condition(s) Overall wellness	s OBoth	1				
Have you ever v	visited a chi	ropracto	r? Yes	O No	If yes, wha	t is their name?						
What is their sp	ecialty?	) Pain R	elief OP	hysical <sup>-</sup>	Therapy & R	ehab O Nutritional O Subluxation	n-based	Oth	ier:			
Do you have an	y health co	ncerns fo	or other fan	nily mer	mbers today	?						
TRAUMAS: I	Physical	Injury	/ History	/								
Have you ever h	, ,	nificant f	alls, surgeri	es or ot	her injuries a	s an adult? Yes No						
Notable childho	od injuries?	O Yes	s No	If yes, p	lease explair	1:						
Youth or college	sports? (	Yes (	No If ye	es, list m	najor injuries							
Any auto accide	nts? O Ye	es O N	o If yes, p	lease ex	kplain:							
Exercise Freque What types of e	•	lone C	) 1-2x per w	veek C	) 3-5x per w	eek O Daily						
How do you nor	mally sleep	o? O B	ack O S	ide 🔘	Stomach	Do you wake up: Refreshed a	nd ready	O Sti	ff and tired	<u> </u>		
Do you commut	te to work?	O Yes	S No	If yes, h	now many m	inutes per day?	<u> </u>					
List any problem	ns with flex	ibility. (e:	x. Putting o	on shoes	s/socks, etc.)							
How many hour	rs per day y	ou typic	ally spend :	sitting a	t a desk or c	n a computer, tablet or phone?						
TOXINS: Ch	emical 8	<del>-</del> Fnvi	ronmen	tal Ex	nosure							
Please rate yo					posurc							
/	None		Moderate		High		None		Modera	te	Hig	gh
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 d	rugs/medic	ations/v	ritamins/he	rbs/oth	er that you a	re taking, and why.						
THOUGHTS	: Emotic	onal St	tresses 8	t Cha	llenges							
Please rate yo												
	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	
ACKNOWLE	DGEMEN	IT & C	ONSENT	-								
Patient Nam	e:							Dat	te:			

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## Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMP	томѕ
Cervical	<ul> <li>Autonomic Nervous System</li> <li>ENT System</li> <li>Vision, Balance &amp; Coordination</li> <li>Speech</li> <li>Immune System</li> <li>Digestive System</li> <li>Nerve Supply to Shoulders, Arms &amp; Hands</li> <li>Sympathetic Nucleus</li> <li>Metabolism</li> </ul>	Colic & Excessive Crying Ear & Sinus Infections Allergies & Congestion Immune Deficiency Headaches & Migraines Vertigo & Dizziness Sore Throat & Strep Swollen Tonsils & Adenoids Vision & Hearing Issues Low Energy & Fatigue Difficulty Sleeping Pain, Numbness & Tingling in Arms to Hands	Epilepsy & Seizures  Sensory & Spectrum  ADD / ADHD  Focus & Memory Issues  Anxiety & Stress  Balance & Coordination  Speech Issues  TMJ / Jaw Pain  Stiff Neck & Shoulders  Depression  High Blood Pressure  Poor Metabolism & Weight Control
Upper Thoracic	<ul><li> Upper G.I.</li><li> Respiratory System</li><li> Cardiac Function</li></ul>	Reflux / GERD Chronic Colds & Cough Asthma	Bronchitis & Pneumonia Functional Heart Conditions
Mid Thoracic	<ul><li>Major Digestive Center</li><li>Detox &amp; Immunity</li></ul>	Gallbladder Pain / Issues Jaundice Fever	Indigestion & Heartburn Stomach Pains & Ulcers Blood Sugar Problems
Lower Thoracic	<ul> <li>Stress Response</li> <li>Filtration &amp; Elimination</li> <li>Gut &amp; Digestion</li> <li>Hormonal Control</li> </ul>	Behavior Issues Hyperactivity Chronic Fatigue Chronic Stress	Allergies & Eczema Skin Conditions / Rash Kidney Problems Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	<ul> <li>Lower G.I.         (Absorption &amp; Motility)</li> <li>Gut-Immune System</li> <li>Major Hormonal Control</li> </ul>	Constipation Chrohn's, Colitis & IBS Diarrhea Bed-wetting Bladder & Urination Issues Cramps & Menstrual Issues Cysts & Endometriosis Infertility Impotency Hemorrhoids	Sciatica & Radiating Pain Lumbopelvic / SI Joint Pain Hamstring Tightness Disc Degeneration Leg Weakness & Cramps Poor Circulation & Cold Feet Knee, Ankle & Foot Pain Weak Ankles & Arches Lower Back Pain Gluten & Casein Intolerance