Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	DOB:
Marital Status:	# of children:	Occupation:
Street Address:		
City:	State:	Zip Code:
Email:	Cell Phone:	
Emergency Contact:	Relation:	Phone:
How did you hear about us?		
Date & Reason for last doctor visit?		
Are you receiving care from any health care providers? Yes No		
-if yes, please name them & their specialty		

TOP 3 HEALTH GOALS

1.

2.

3.

CURRENT HEALTH CONDITIONS

What health conditions bring you into our office?

Have you received care for this problem before? Yes No

When did the condition(s) first begin?

Please indicate where you are experiencing pain or discomfort.

X= Current condition O= Past condition

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care?

Resolve existing condition(s) Overall Wellness Both

Please explain:

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

When was your last adjustment? How often were you getting adjusted?

TRAUMAS: PHYSICAL INJURY HISTORY

Have you had any significant falls, surgeries or other injuries? Yes No If yes, please explain:
Any auto accidents? Yes No If yes, please explain:
Exercise Frequency: What type of exercise?
Do commute to work? Yes No If yes, how many minutes per day?
How many hours per day do you spend sitting at a desk or on a computer, tablet or phone?

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

Photo Consent

I hereby authorize Abundant Life Chiropractic to use my testimonial and any information contained herein, including photos and video, in its public relation efforts. I understand and approve the disclosure of testimonial information, photos and video to the media, social media and other individuals and entities that may be involved in the public relations efforts of Abundant Life Chiropractic, including but not limited to Abundant Life Chiropractic's Facebook page, Instagram page, and in-office displays. By signing below I agree and acknowledge that I have read and understood the above and Release, have had the opportunity to ask questions about it, and agree to all terms described. (please check the box that applies)

Yes, I consent to take and use photos No, I do not consent to photos.

____ ____________________

Patient Name (Printed) Date Signed

____ ____________________

Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Witness to Signature

____ ____________________

Doctor of Chiropractic Signature Date Signed

Patient Review of Symptoms

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

REGIONS	FUNCTIONS	SYMPTOMS	
CERVICAL	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐ 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	• Upper G.I. • Respiratory System • Cardiac Function	☐ Reflux / GERD ☐ Chronic Colds & Cough ☐ Asthma	☐ Bronchitis & Pneumonia ☐ Functional Heart Conditions
MID THORACIC	• Major Digestive Center • Detox & Immunity	☐ Gallbladder Pain / Issues ☐ Jaundice ☐ Fever	☐ Indigestion & Heartburn ☐ Stomach Pains & Ulcers ☐ Blood Sugar Problems
LOWER THORACIC	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐ Behavior Issues ☐ Hyperactivity ☐ Chronic Fatigue ☐ Chronic Stress	☐ Allergies & Eczema ☐ Skin Conditions / Rash ☐ Kidney Problems ☐ Gas Pain & Bloating
LUMBAR	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐ 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

Doctor's Use Only

Prior D/C Y N

ROF:

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Notes

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GOALS

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