Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS#:	DOB:	Sex: ◯ M ◯ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Postal Code:		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:

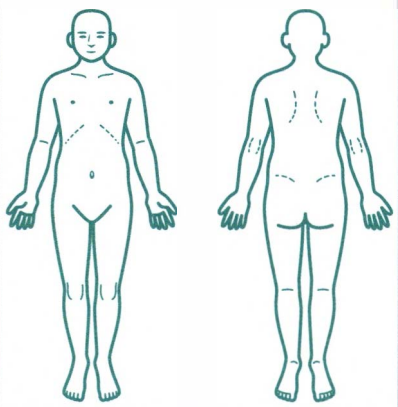
Are you also receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

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

Please indicate where you are experiencing pain or discomfort.
X= Current condition O= Past condition



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?

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 ◯ 1-3x per week ◯ 4-6x 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		*Moderate*		*High*			*None*		*Moderate*		*High*
Alcohol	◯	◯	◯	◯	◯		Processed Foods	◯	◯	◯	◯	◯
Water	◯	◯	◯	◯	◯		Artificial Sweeteners	◯	◯	◯	◯	◯
Sugar	◯	◯	◯	◯	◯		Sugary Drinks	◯	◯	◯	◯	◯
Dairy	◯	◯	◯	◯	◯		Cigarettes	◯	◯	◯	◯	◯
Gluten	◯	◯	◯	◯	◯		Recreational Drugs	◯	◯	◯	◯	◯

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		*Moderate*		*High*			*None*		*Moderate*		*High*
Home	◯	◯	◯	◯	◯		Money	◯	◯	◯	◯	◯
Work	◯	◯	◯	◯	◯		Health	◯	◯	◯	◯	◯
Life	◯	◯	◯	◯	◯		Family	◯	◯	◯	◯	◯

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: _____