Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: M F
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:

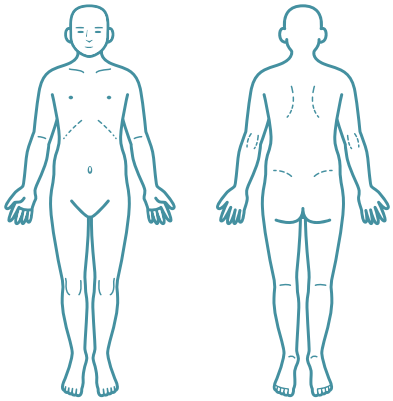
Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

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

Please indicate 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 ◯ 1-2x per week ◯ 3-5x 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	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/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

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: __/__/____

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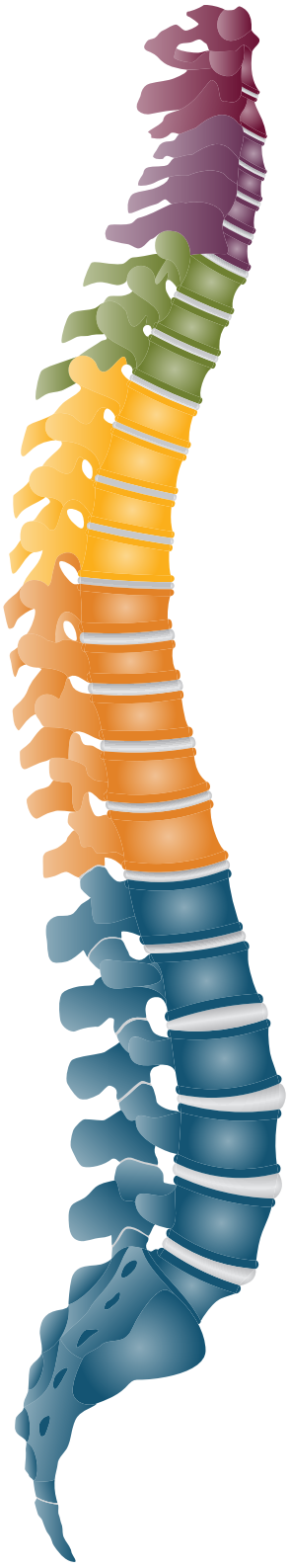
Patient Review of Systems

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

Patient Name: _____ Date: ___/___/___