Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
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 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?

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

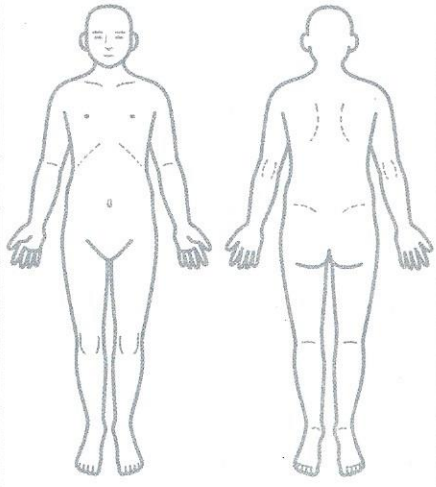
Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X = Current condition; O = Past condition



Your Health Goals

What are 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 ◯ Nutrition ◯ 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 past auto accidents? ◯ Yes ◯ No – If yes, please explain:

How often do you exercise? ◯ 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 do you typically spend sitting at a desk? 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 or 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 Signature: _____ Date: _____