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

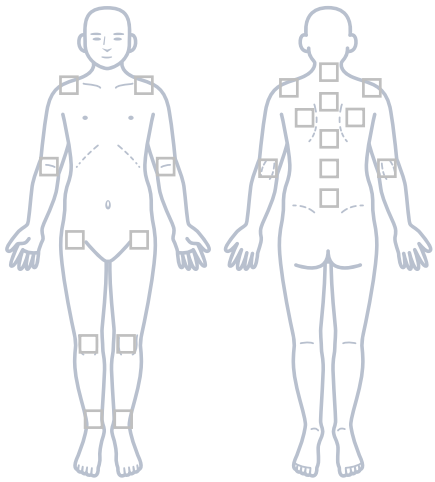
Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

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: _____

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