Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:		Date:
DOB:	Height:	Weight:	Sex:
Marital Status:	# of Children:		Occupation:
Street Address:			
City:	Province:		Postal Code:
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:

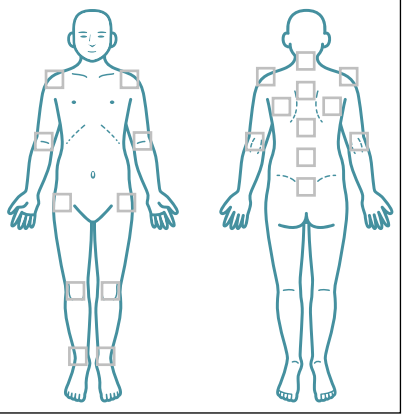
Please note any significant family medical history: ◯ Diabetes ◯ Cancer ◯ Stroke ◯ Heart disease ◯ Other:

CURRENT HEALTH CONDITIONS

What is your primary concern or health condition that brings you into our office? Please describe in detail:

Please indicate where you are experiencing pain or discomfort.

X=Current 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?

Please rate the severity: *Minor* • ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ • *Major*

Any other secondary concerns?

Have you had any of the following: ◯ X-ray ◯ CT ◯ MRI ◯ Ultrasound

Please write when & where they were taken:

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?

When did you go?

Why did you go?

How long did you go?

How often did you go?

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Please list all physical traumas: ◯ Surgeries. Date: _____ ◯ Injuries. Date: _____

◯ Slips or Falls. Date: _____ ◯ Fractures/Broken Bones. Date: _____

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

Any other diagnoses or health concerns?

Anything else you would like the Doctor to know?

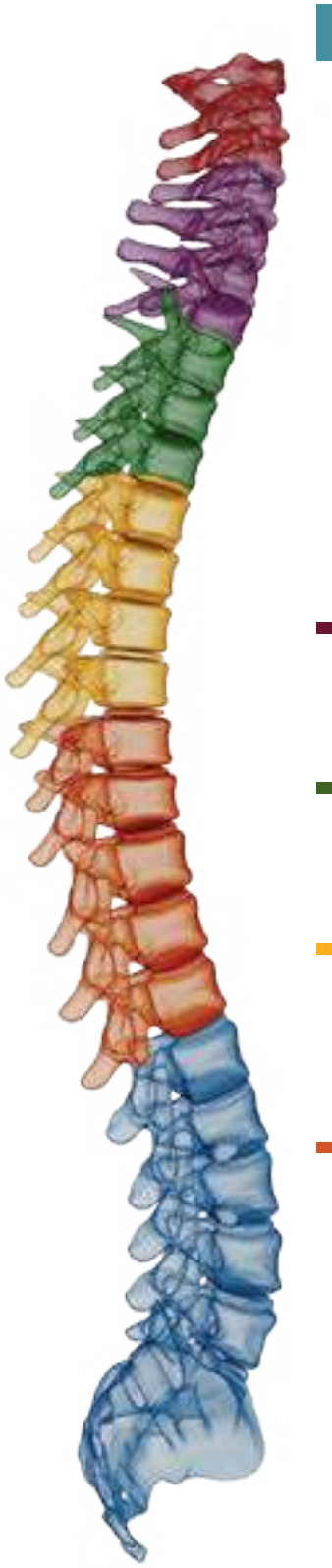
ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ DOB _____ Date: _____

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
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, Sacrum & Pelvis	• 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	☐	☐

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