Chiropractic
Health Questionnaire
(Adult)

Today's Date: _____

Name:_____ Sex: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip Code:_____

Preferred Phone Number: _____ Home Cell Work

Email Address: _____

Occupation: _____ Employed By: _____

Marital Status: (Circle one) single married divorced widowed

What health concerns brought you to our office?

_____

_____

How did you hear about our office? _____

Have you ever been to a doctor of chiropractic? __ Yes __ No

What surgeries have you had?

Date Surgery

_____

_____

_____

What significant injuries have you had?

Date Injury

_____

_____

What medications do you take?

Medication Condition for which you take this medication

Do you take vitamins/supplements? ____ Yes ____ No

Do you exercise? ____ Yes ____ No

Do you use tobacco products? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No

Do you drink caffeinated beverages? ____ Yes ____ No

Patient's Signature Date