

# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS#:	DOB:	Sex: <input type="radio"/> M <input type="radio"/> F
Marital Status:	# of Children:	Occupation:
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 also receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> 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

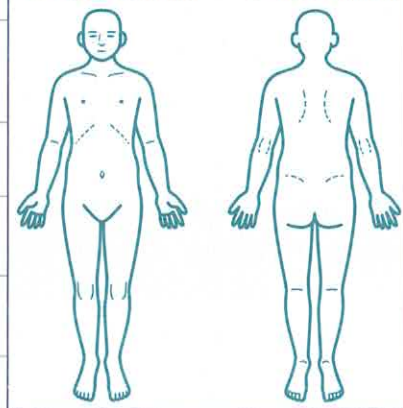
Is this condition:  Getting worse  Improving  Intermittent  Constant  Unsure

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

Your top three health goals:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

# 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  1-3x 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 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: \_\_\_\_\_