Adult Patient Questionnaire

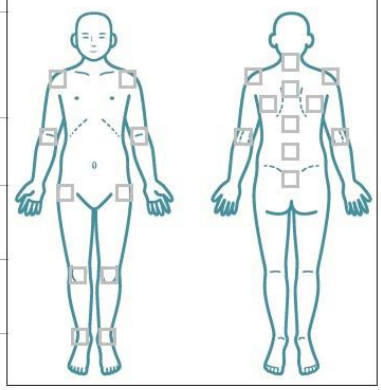
CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
DOB: / /	Sex: M F	Marital Status:
Street Address:	City:	State: Zip:
# of Children:	Names/Ages of Children:	
Height: ft. in.	Weight: lbs	
Email:	Cell Phone: - -	
Emergency Contact:	Emergency Phone: - -	
Employer:	Occupation:	
How did you hear about us?		
Health insurance provider:	ID number:	

CURRENT HEALTH CONDITIONS

What health condition(s) bring you in to our office?

Please indicate where you are experiencing pain or discomfort.



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?

On a scale of 0-10, how much does your problem bother you?

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

CHIROPRACTIC History

Have you ever visited a chiropractor? Yes No If yes, what is their name?

What would you like to gain from chiropractic care in our office?

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

PHYSICAL Stress 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 1-2x 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

List any problems with flexibility (ex. Putting on shoes/socks, etc)

How many hours per day do you typically spend sitting at a desk or on a phone?

CHEMICAL Stress History

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 that you are taking and why

EMOTIONAL Stress History

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: / /

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL CELLS IN THE BODY

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

REGIONS	SYMPTOMS			
	PAST	PRESENT	PAST	PRESENT
Cervical	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
	☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
	☐	☐ Allergies & Congestion	☐	☐ ADD/ADHD
	☐	☐ Migraines	☐	☐ Focus & Memory Issues
	☐	☐ Headaches	☐	☐ Anxiety & Stress
	☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
	☐	☐ Sore Throat	☐	☐ Speech Issues
	☐	☐ Swollen Tonsils	☐	☐ TMJ / Jaw Pain
	☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
	☐	☐ Low Energy & Fatigue	☐	☐ Depression
	☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
	☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
	☐	☐ Chronic Colds & Cough	☐	☐ Heart Condition
	☐	☐ Asthma		
Mid Thoracic	☐	☐ Gallbladder Issues	☐	☐ Indigestion & Heartburn
	☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
	☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
	☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
	☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
	☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum, & Pelvis	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
	☐	☐ Crohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
	☐	☐ Diarrhea	☐	☐ Hamstring Tightness
	☐	☐ Bed-wetting	☐	☐ Disc Degeneration
	☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
	☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
	☐	☐ Cysts & Endometriosis	☐	☐ Knee , Ankle & Foot Pain
	☐	☐ Infertility	☐	☐ Weak Ankles & Arches
	☐	☐ Impotency	☐	☐ Lower Back Pain
	☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: / /