

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: ft. in.	
City:	State: Zip:	Weight: lbs.
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

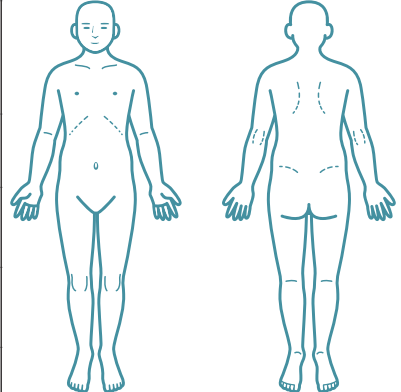
Is this condition: Getting worse Improving Intermittent Constant Unsure

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 1-2x 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:

	<i>None</i>						<i>Moderate</i>						<i>High</i>				
	1	2	3	4	5		1	2	3	4	5		1	2	3	4	5
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:

	<i>None</i>						<i>Moderate</i>						<i>High</i>				
	1	2	3	4	5		1	2	3	4	5		1	2	3	4	5
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: ____ / ____ / ____



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