

# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

First Name:

Last Name:

Date:

SS #:

DOB:

Sex:  M  F

Marital Status:

# of Children:

Occupation:

Street Address:

Height:

City, State, Zip:

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?  Yes  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

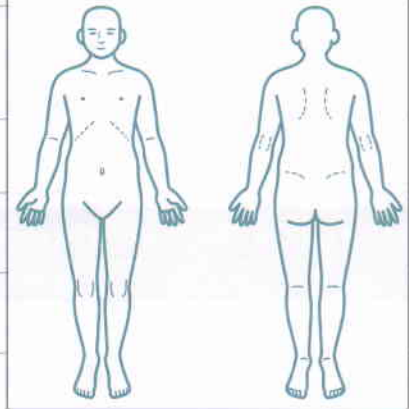
What makes the problem better?

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:

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?

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  3-6x 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 & Sweets	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

## ACKNOWLEDGMENT & CONSENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_