# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

| | | |
|---|---|---|
| First Name: | Last Name: | Date: / / |
| SS#: - - | DOB: / / | Sex: M 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? Yes No

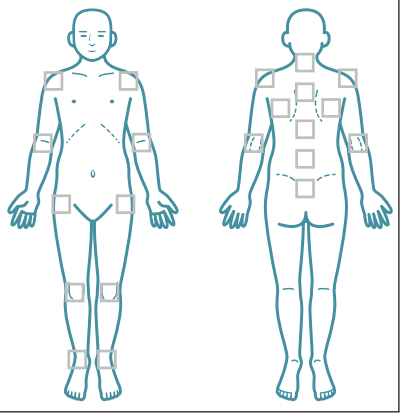
- If yes, please name them and their specialty:

Please note any significant family medical history:

## CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

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? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

## 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 ◯ 3-5x 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:

| | *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: __/__/____

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