Adult Patient Questionnaire

Confidential Patient Information	on	
First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
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 vis	sit?	
Are you receiving care from any other hand their space of the space of		
Please note any significant family media	cal history:	
Current Health Conditions		
What health condition(s) bring you into	our office?	Please indicate where you are
		experiencing pain or discomfort.
		X=Current condition; O=Past condition
Have you received care for this problem	n before? O Yes O No	X=Current condition; O=Past condition
Have you received care for this problem – If yes, please explain:	n before? O Yes O No	X=Current condition; O=Past condition
- If yes, please explain:	n before? O Yes O No	X=Current condition; O=Past condition
- If yes, please explain: When did the condition(s) first begin?		X=Current condition; O=Past condition
If yes, please explain:When did the condition(s) first begin?How did the problem start?Sudden	enly O Gradually O Post-Injury	
If yes, please explain:When did the condition(s) first begin?How did the problem start? Sudden		
If yes, please explain:When did the condition(s) first begin?How did the problem start?Sudden	enly O Gradually O Post-Injury	
- If yes, please explain: When did the condition(s) first begin? How did the problem start? ○ Sudden Is this condition: ○ Getting worse What makes the problem better?	enly O Gradually O Post-Injury	
 If yes, please explain: When did the condition(s) first begin? How did the problem start? Suddens Is this condition: Getting worse 	enly O Gradually O Post-Injury	
- If yes, please explain: When did the condition(s) first begin? How did the problem start? ○ Sudden Is this condition: ○ Getting worse What makes the problem better?	enly O Gradually O Post-Injury	
 If yes, please explain: When did the condition(s) first begin? How did the problem start? Suddents Is this condition: Getting worse What makes the problem better? What makes the problem worse? 	enly O Gradually O Post-Injury	
- If yes, please explain: When did the condition(s) first begin? How did the problem start? ○ Sudden Is this condition: ○ Getting worse What makes the problem better? What makes the problem worse? Your Health Goals	enly O Gradually O Post-Injury	
 If yes, please explain: When did the condition(s) first begin? How did the problem start? Suddensity Is this condition: Getting worse What makes the problem better? What makes the problem worse? Your Health Goals What are your top three health goals? 	enly O Gradually O Post-Injury	
 If yes, please explain: When did the condition(s) first begin? How did the problem start? Suddensity Is this condition: Getting worse What makes the problem better? What makes the problem worse? Your Health Goals What are your top three health goals? 	enly O Gradually O Post-Injury	

Chiropract	ic History										
					O Resolve existi		vellness ———————	O Both		·	——————————————————————————————————
Have you eve	er visited a ch	niropracto			No - If yes, wha						
- What is the	ir specialty?	O Pain	Relief () Phys ——	ical Therapy & Ref	nab O Nutrition O Sublux	kation-base	ed 00 	ther: —— —		
Do you have	any health c	oncerns i	for other fa	mily m	embers today?						
TRAUMAS	S: Physica	1 Injury	History								
Have you eve	er had any si	gnificant	falls, surge	ries or	other injuries as ar	n adult? O Yes O No					
- If yes, pleas	se explain:										
Notable child			Yes 01	 No -	If yes, please expla						
Youth or coll					If yes, list major inj						
					If yes, please expla						
Any past aut			-		per week 0 4-6						= =
How often de - What types	•		None C) 1-3X	per week 04-c	ox per week					
How do you	normally slee	ep? O	Back C) Side	O Stomach	Do you wake up: OR	efreshed a	nd ready	O Stiff a	and tired	l
Do you com	mute to work	O</td <td>Yes O</td> <td>No -</td> <td>If yes, how many r</td> <td>minutes per day?</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Yes O	No -	If yes, how many r	minutes per day?					
List any prob	olems with fle	exibility (e.	x. putting o	n shoe	es/socks, etc):						
How many h	ours per day	do you t	typically sp	end sit	ting at a desk?	On a computer	, tablet or p	ohone?			
_											
TOXINS: (Chemical a	& Envir	onmenta	al Exp	osure				· -		
TOXINS: (Chemical of your CONS				osure						
					osure High		None		Moderate		High
	your CONS		ON for eac			Processed Foods	None ①	2	Moderate	•	High ⑤
Please rate	your CONS	SUMPTIC	ON for eac	:h:	Hìgh	Processed Foods Artificial Sweeteners		② ②		④	
Please rate	your CONS None	SUMPTIC ②	ON for each	ch:	High ⑤		①		3	_	6
Please rate Alcohol Water	your CONS None ① ①	© ②	ON for each Moderate 3 3	sh: ④ ④	High ⑤ ⑤	Artificial Sweeteners	① ①	2	③ ③	④	66
Please rate Alcohol Water Sugar	your CONS None 1 1	© 2 2 2	Moderate 3 3 3	eh:	High ⑤ ⑤ ⑥	Artificial Sweeteners Sugary Drinks	① ① ①	② ②	③ ③ ③	44	6 6 6
Alcohol Water Sugar Dairy Gluten	your CONS None ① ① ① ① ① ① ①	2 2 2 2 2	Moderate 3 3 3 3 3	eh:	High (5) (5) (6) (5)	Artificial Sweeteners Sugary Drinks Cigarettes	① ① ① ①	② ② ②	3 3 3	44	6 6 6 6
Alcohol Water Sugar Dairy Gluten	your CONS None ① ① ① ① ① ① ①	2 2 2 2 2	Moderate 3 3 3 3 3	eh:	High (5) (5) (6) (5)	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	① ① ① ①	② ② ②	3 3 3	44	6 6 6 6
Alcohol Water Sugar Dairy Gluten	your CONS None ① ① ① ① ① ① ①	2 2 2 2 2	Moderate 3 3 3 3 3	eh:	High (5) (5) (6) (5)	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	① ① ① ①	② ② ②	3 3 3	44	6 6 6 6
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Alcohol Water Sugar Dairy Gluten	None ① ① ① ① ① ① ① ① ① ① ① ① ① ① ① ① ① ① TS: Emotion	② ② ② ② ③ odications	Moderate 3 3 3 3 3 4 5 7 8 9 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	•h: ④ ④ ④ ④ ④ (herbs	High ⑤ ⑤ ⑥ ⑥ ⑥ ⑥ or other that you a	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	① ① ① ①	② ② ②	3 3 3	44	6 6 6 6
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