

Adult Patient Questionnaire

Confidential Patient Information

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 visit?		
Are you 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?

Please indicate where you are experiencing pain or discomfort.

X = Current condition; O = Past condition

Have you received care for this problem before? Yes No

– If yes, please explain:

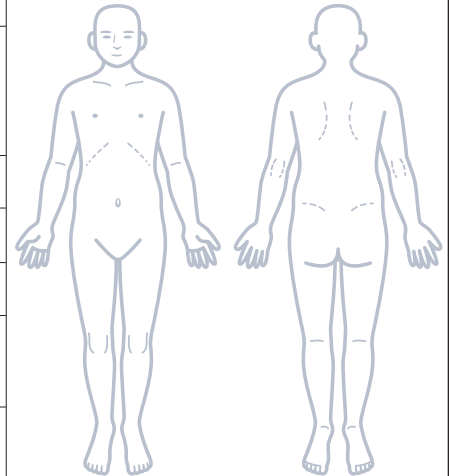
When did the condition(s) first begin?

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

What are 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 Nutrition 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 past auto accidents? Yes No – If yes, please explain:

How often do you exercise? None 1-3x per week 4-6x 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 do you typically spend sitting at a desk? _____ On a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Alcohol	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Water	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugar	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Dairy	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Gluten	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Processed Foods	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Artificial Sweeteners	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugary Drinks	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Cigarettes	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Recreational Drugs	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs or other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Home	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Work	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Life	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Money	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Health	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Family	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Acknowledgement & Consent

Patient Signature: _____

Date: _____

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