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 profes – If yes, please name them and their specialty: Please note any significant family medical history:	sionals? O Yes O No	
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? – If yes, please explain:	○ Yes ○ No	X=Current condition; O=Past condition
When did the condition(s) first begin?		
How did the problem start? Suddenly G	radually O Post-Injury	(\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Is this condition:	g OIntermittent OConstant OUnsure	\
What makes the problem better?		
What makes the problem worse?		
Your Health Goals		
What are your top three health goals?		
1		
2		

Chiropract	ic History	/										
What would y	ou like to ga	ain from	chiropraction	c care?	O Resolve e	existing condition(s) Overall	wellness	O Both)			
Have you eve	er visited a c	hiroprac	tor? OYe	es O	No - If yes, v	what is their name?						
- What is thei	ir specialty?	○ Pa	in Relief () Phys	ical Therapy &	Rehab O Nutrition O Sublu	xation-bas	ed O	Other:			
Do you have a	any health c	concerns	s for other fa	amily m	embers today?	?						
TRAUMAS	: Physica	al Injury	y History									
Have you eve	-	ignifican	t falls, surge	eries or	other injuries a	as an adult? O Yes O No						
	•											
Notable childl	hood injurie:	s? (Yes OI	No -	If yes, please e	explain:						
Youth or college sports?												
Any past auto accidents?												
How often do - What types	-		None () 1-3x	per week O	4-6x per week O Daily						
How do you r	normally slee	ep?	Back C) Side	Stomach	Do you wake up: OR	efreshed a	ınd ready	Stiff a	ınd tirec	t	
Do you comm	nute to work	(</td <td>Yes O</td> <td>No -</td> <td>If yes, how ma</td> <td>ny minutes per day?</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Yes O	No -	If yes, how ma	ny minutes per day?						
List any probl	ems with fle	exibility (e	ex. putting c	on shoe	es/socks, etc):							
How many ho	ours per day	/ do you	typically sp	end sit	ting at a desk?	On a computer	, tablet or	phone?				
TOXINS: C	Chemical	& Envi	ronmenta	al Exp	osure							
TOXINS: C					osure							
Please rate y	your CONS	SUMPTI	ON for eac	h:	High		None		Moderate		High	
Please rate y	your CONS None 1	©	ON for eac	ch: (4)	High ⑤	Processed Foods	1	2	3	4	5	
Please rate y Alcohol Water	your CONS None 1 1	2 2	ON for each	ch: 4 4	High ⑤ ⑤	Artificial Sweeteners	1	2	33	4	55	
Alcohol Water Sugar	None 1 1 1	2 2 2 2	ON for each Moderate (3) (3) (3)	eh: 4 4 4 4	High (5) (6)	Artificial Sweeteners Sugary Drinks	1) 1) 1)	2	333	4	(5)(5)(6)	
Alcohol Water Sugar Dairy	None 1 1 1 1	© 2 2 2 2 2	ON for each Moderate 3 3 3 3 3	4 4 4 4	High	Artificial Sweeteners Sugary Drinks Cigarettes	1 1 1	② ② ②	3 3 3 3	4 4	(5)(5)(5)(5)	
Alcohol Water Sugar Dairy Gluten	None 1 1 1 1 1	2 2 2 2 2 2	Moderate 3 3 3 3 3 3	4 4 4 4 4	High	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	1) 1) 1)	2	333	4	(5)(5)(6)	
Alcohol Water Sugar Dairy Gluten	None 1 1 1 1 1	2 2 2 2 2 2	Moderate 3 3 3 3 3 3	4 4 4 4 4	High	Artificial Sweeteners Sugary Drinks Cigarettes	1 1 1	② ② ②	3 3 3 3	4 4	(5)(5)(5)(5)	
Alcohol Water Sugar Dairy Gluten	None 1 1 1 1 1	2 2 2 2 2 2	Moderate 3 3 3 3 3 3	4 4 4 4 4	High	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	1 1 1	② ② ②	3 3 3 3	4 4	(5)(5)(5)(5)	
Alcohol Water Sugar Dairy Gluten Please list any	None 1 1 1 1 1 y drugs/me	② ② ② ② ② ② ② ② ③ Odication	Moderate 3 3 3 3 3 3 x	4 4 4 4 4 7 herbs	High 6 5 6 6 5 or other that yo	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	1 1 1	② ② ②	3 3 3 3	4 4	(5)(5)(5)(5)	
Alcohol Water Sugar Dairy Gluten	None 1 1 1 1 1 y drugs/me	② ② ② ② ② ② ② ② ② Ordication	Moderate 3 3 3 3 3 s/vitamins/	4 4 4 4 4 7 herbs	High 6 5 6 6 5 or other that yo	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	1 1 1	② ② ②	3 3 3 3	4 4	(5)(6)(5)(6)	
Alcohol Water Sugar Dairy Gluten Please list any	None 1 1 1 1 1 y drugs/me	② ② ② ② ② ② ② ② ② Ordication	Moderate 3 3 3 3 3 s/vitamins/	4 4 4 4 4 7 herbs	High ⑤ ⑥ ⑤ ⑥ ⑥ ⑥ or other that you	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	1 1 1	② ② ②	3 3 3 3	4 4	(5)(6)(5)(6)	
Alcohol Water Sugar Dairy Gluten Please list any	None 1 1 1 1 y drugs/me	② ② ② ② ② ② ② ② ② Ordication	Moderate 3 3 3 3 3 s/vitamins/	4 4 4 4 4 7 herbs	High 6 5 6 6 5 or other that yo	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs	10 10 10 10 10 10 10 10 10 10 10 10 10 1	② ② ②	3 3 3 3 3	4 4	6 6 6 6 6	
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Alcohol Water Sugar Dairy Gluten Please list any THOUGHT Please rate y	None 1 1 1 1 1 y drugs/me S: Emotion None 1	② ② ② ② ② ② ② Onal S SS for €	Moderate 3 3 3 3 3 s/vitamins/	4 4 4 Chal	High 6 6 6 6 5 5 or other that your lenges High 6	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs ou are taking and why: Money	(1) (1) (1) (1) (1) (1)	2 2	3 3 3 3 3 Moderate 3	4 4 4	6 6 6 6 6 High 6	
Alcohol Water Sugar Dairy Gluten Please list any THOUGHT Please rate y Home Work Life	your CONS None 1 1 1 1 y drugs/me S: Emotion Your STRES None 1 1 1 1	© ② ② ② ② ② ③ dication onal S SS for 6 ② ② ②	Moderate 3 3 3 3 3 s/vitamins/	4 4 4 Chal	High \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Artificial Sweeteners Sugary Drinks Cigarettes Recreational Drugs ou are taking and why: Money Health	(1) (1) (1) (1) (1) (1)	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	(3) (3) (3) (3) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	4 4 4 4 4 4	6 6 6 6 6 High 6 6	
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