

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? ☐ 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.

X=Current condition; O=Past condition

Have you received care for this problem before? ☐ Yes ☐ No

– If yes, please explain:

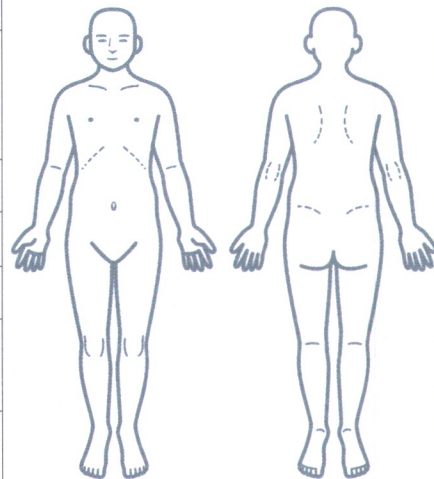
When did the condition(s) first begin?

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		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 or 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 Signature: _____

Date: _____