Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ Gender: _____ Marital Status: _____

Who can we thank for your referral? _____ # of Children: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

Email: _____

Primary Care Physician: _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Phone: _____ Relationship: _____

CURRENT HEALTH CONDITIONS

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

_____

_____

_____

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

If yes, where, and have you had previous imaging?

_____

When did the condition(s) first begin? _____

How did the problem start?

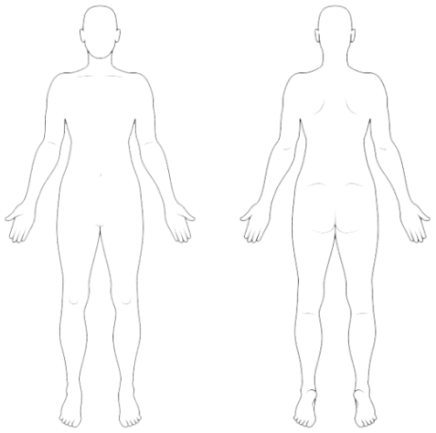
☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting Worse ☑ Improving

☐ Intermittent ☐ Constant ☐ Unsure

Please indicate where you are experiencing pain or discomfort

X = Current Condition O = Past Condition



What makes this problem better? _____

What makes this problem worse? _____

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:

_____

_____

Please list your top three health goals: _____

_____

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? _____

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 Explain: _____

Youth or college sports: ☐ Yes ☐ No Explain: _____

Any past auto accidents? ☐ Yes ☐ No 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

You wake up: ☐ Refreshed and ready ☐ Stiff and tired

TOXINS (CHEMICAL & ENVIRONMENTAL EXPOSURE)

Please rate your CONSUMPTION for each:

Alcohol:	☐ None	☐ Moderate	☐ High	Processed Foods:	☐ None	☐ Moderate	☐ High
Water:	☐ None	☐ Moderate	☐ High	Artificial Sweeteners:	☐ None	☐ Moderate	☐ High
Sugar:	☐ None	☐ Moderate	☐ High	Caffeine:	☐ None	☐ Moderate	☐ High
Dairy:	☐ None	☐ Moderate	☐ High	Tobacco:	☐ None	☐ Moderate	☐ High
Gluten:	☐ None	☐ Moderate	☐ High	Recreational Drugs:	☐ None	☐ Moderate	☐ High

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

NAME	DOSAGE	REASON FOR TAKING

THOUGHTS (EMOTIONAL STRESSES & CHALLENGES)

Please rate your STRESS for each:

Home:	☐ None	☐ Moderate	☐ High	Money:	☐ None	☐ Moderate	☐ High
Work:	☐ None	☐ Moderate	☐ High	Health:	☐ None	☐ Moderate	☐ High
Life:	☐ None	☐ Moderate	☐ High	Family:	☐ None	☐ Moderate	☐ High

ACKNOWLEDGEMENT & CONSENT

I certify that I understand that providing a full health history is imperative for the doctor(s) to make the best plan and choices for care. I affirm that I have thoroughly and honestly completed these intake forms to the best of my ability. I acknowledge that a comprehensive evaluation is necessary to determine the next steps most appropriate in this case.

Patient Signature: _____ Date: _____