# *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?

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

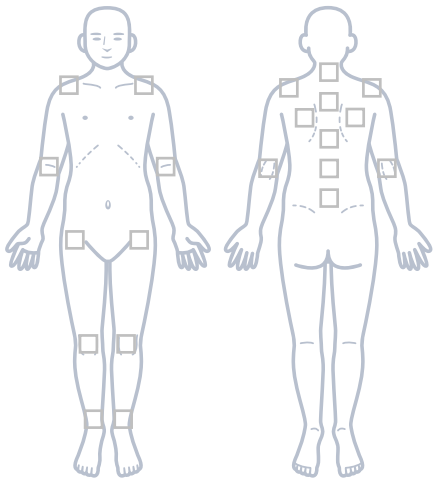
Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

**Please indicate where you are experiencing pain or discomfort.**

X = Current condition; O = Past condition



## 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: _____

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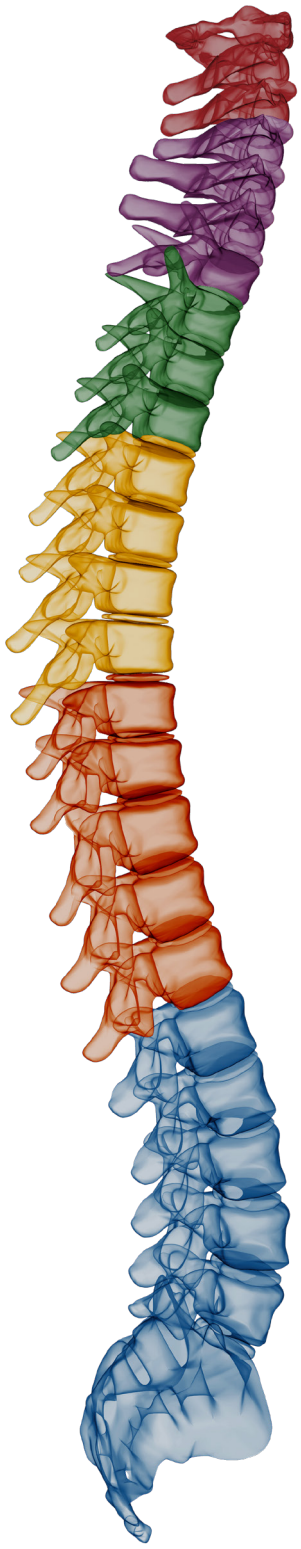
# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

*Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.*



| REGIONS | FUNCTIONS | SYMPTOMS | | | |
|---|---|---|---|---|---|
| | | PAST | PRESENT | | PAST | PRESENT | |
| **Cervical** | • Autonomic Nervous System<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System<br>• Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Sympathetic Nucleus<br>• Metabolism | ☐ | ☐ | Colic & Excessive Crying | ☐ | ☐ | Epilepsy & Seizures |
| | | ☐ | ☐ | Ear & Sinus Infections | ☐ | ☐ | Sensory & Spectrum |
| | | ☐ | ☐ | Allergies & Congestion | ☐ | ☐ | ADD / ADHD |
| | | ☐ | ☐ | Immune Deficiency | ☐ | ☐ | Focus & Memory Issues |
| | | ☐ | ☐ | Headaches & Migraines | ☐ | ☐ | Anxiety & Stress |
| | | ☐ | ☐ | Vertigo & Dizziness | ☐ | ☐ | Balance & Coordination |
| | | ☐ | ☐ | Sore Throat & Strep | ☐ | ☐ | Speech Issues |
| | | ☐ | ☐ | Swollen Tonsils & Adenoids | ☐ | ☐ | TMJ / Jaw Pain |
| | | ☐ | ☐ | Vision & Hearing Issues | ☐ | ☐ | Stiff Neck & Shoulders |
| | | ☐ | ☐ | Low Energy & Fatigue | ☐ | ☐ | Depression |
| | | ☐ | ☐ | Difficulty Sleeping | ☐ | ☐ | High Blood Pressure |
| | | ☐ | ☐ | Pain, Numbness & Tingling in Arms to Hands | ☐ | ☐ | Poor Metabolism & Weight Control |
| **Upper Thoracic** | • Upper G.I.<br>• Respiratory System<br>• Cardiac Function | ☐ | ☐ | Reflux / GERD | ☐ | ☐ | Bronchitis & Pneumonia |
| | | ☐ | ☐ | Chronic Colds & Cough | ☐ | ☐ | Functional Heart Conditions |
| | | ☐ | ☐ | Asthma | | | |
| **Mid Thoracic** | • Major Digestive Center<br>• Detox & Immunity | ☐ | ☐ | Gallbladder Pain / Issues | ☐ | ☐ | Indigestion & Heartburn |
| | | ☐ | ☐ | Jaundice | ☐ | ☐ | Stomach Pains & Ulcers |
| | | ☐ | ☐ | Fever | ☐ | ☐ | Blood Sugar Problems |
| **Lower Thoracic** | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐ | ☐ | Behavior Issues | ☐ | ☐ | Allergies & Eczema |
| | | ☐ | ☐ | Hyperactivity | ☐ | ☐ | Skin Conditions / Rash |
| | | ☐ | ☐ | Chronic Fatigue | ☐ | ☐ | Kidney Problems |
| | | ☐ | ☐ | Chronic Stress | ☐ | ☐ | Gas Pain & Bloating |
| **Lumbar, Sacrum & Pelvis** | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐ | ☐ | Constipation | ☐ | ☐ | Sciatica & Radiating Pain |
| | | ☐ | ☐ | Chrohn's, Colitis & IBS | ☐ | ☐ | Lumbopelvic / SI Joint Pain |
| | | ☐ | ☐ | Diarrhea | ☐ | ☐ | Hamstring Tightness |
| | | ☐ | ☐ | Bed-wetting | ☐ | ☐ | Disc Degeneration |
| | | ☐ | ☐ | Bladder & Urination Issues | ☐ | ☐ | Leg Weakness & Cramps |
| | | ☐ | ☐ | Cramps & Menstrual Issues | ☐ | ☐ | Poor Circulation & Cold Feet |
| | | ☐ | ☐ | Cysts & Endometriosis | ☐ | ☐ | Knee, Ankle & Foot Pain |
| | | ☐ | ☐ | Infertility | ☐ | ☐ | Weak Ankles & Arches |
| | | ☐ | ☐ | Impotency | ☐ | ☐ | Lower Back Pain |
| | | ☐ | ☐ | Hemorrhoids | ☐ | ☐ | Gluten & Casein Intolerance |

Patient Name: _____ Date: _____



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