Well.
FAMILY CHIROPRACTIC

ADULT PATIENT QUESTIONNAIRE

CONFIDENTIAL PATIENT INFORMATION		
First Name:	Last Name:	Date:
SS#:	DOB:	Sex: □ M □ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Zip Code:		Weight:
E-mail:	Cell Phone:	Other Phone:
Emergency Contact:	Relation:	Phone:
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also 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?

YOUR HEALTH GOALS
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 (If yes, what is their name? _____) □ No What is their specialty? □ Pain Relief □ Physical Therapy/ Rehab □ Nutritional □ 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, please list major injuries:
Any auto accidents? □ Yes □ No If yes, please explain:
Exercise Frequency? □ 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 or computer, tablet or phone?

TOXINS: Chemical and Environmental Exposure
Please rate your **consumption** for each:

1= None, 5= 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/ other that you are taking, and why:

THOUGHTS: Emotional Stresses and Challenges
Please rate your **stress** for each:

1= None, 5= 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: _____