

Adult Patient Questionnaire

Your first visit to our center is an opportunity for us to learn all about you and your family. It's a time for you to share with us where you are now in your health and life, as well as what you would like to move towards.

Personal Information

Name: _____ DOB: / / Today's Date: / /

Street Address:

City: _____ State: _____ Zip: _____

Phone (cell): _____ (work): _____

Email Address:

Single Married Widowed Divorced

Spouse's Name: _____ # Children _____

How many live at home:

- Names & ages:

Occupation: _____ Self-employed YES NO

Have you ever been to a chiropractor before? YES NO Date of last visit: / /

Dr.'s Name: _____ City: _____ State: _____

- Good Results: YES NO

Are you under care of any other doctor? YES NO

- If Yes, what is the condition you are being treated for?

Please check if you are here for any of the following:

Motor Vehicle Injury Work Injury Other

Whom may we thank for referring you to our center:

Favorite hobbies or interests:

Let's find out why you are here...

Reason for seeking chiropractic care:

Any Other specific concerns:

List all medications and conditions being treated:

List any past surgeries and dates:

List any past accidents/injuries/falls and dates:

Have you ever been under chiropractic wellness care?: YES NO

Quality of Life Inventory

If you have experienced any of the following, please indicate by checking past, current, or both.

	<i>Past</i>	<i>Current</i>		<i>Past</i>	<i>Current</i>		<i>Past</i>	<i>Current</i>
Allergies	<input type="radio"/>	<input type="radio"/>	Frequent colds	<input type="radio"/>	<input type="radio"/>	Neck pain/stiffness	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	Nervousness	<input type="radio"/>	<input type="radio"/>
Arm/hand pain	<input type="radio"/>	<input type="radio"/>	Heart problems	<input type="radio"/>	<input type="radio"/>	Numbness in fingers	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Hip pain	<input type="radio"/>	<input type="radio"/>	Numbness in toes	<input type="radio"/>	<input type="radio"/>
Brain fog	<input type="radio"/>	<input type="radio"/>	Hot flashes	<input type="radio"/>	<input type="radio"/>	Pin / needles in arms	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Irritability	<input type="radio"/>	<input type="radio"/>	Pins / needles in legs	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Joint pain	<input type="radio"/>	<input type="radio"/>	Ringling in ears	<input type="radio"/>	<input type="radio"/>
Cold feet	<input type="radio"/>	<input type="radio"/>	Leg/foot pain	<input type="radio"/>	<input type="radio"/>	Shoulder pain	<input type="radio"/>	<input type="radio"/>
Cold hands	<input type="radio"/>	<input type="radio"/>	Lights bother eyes	<input type="radio"/>	<input type="radio"/>	Sinus congestion	<input type="radio"/>	<input type="radio"/>
Cold sweats	<input type="radio"/>	<input type="radio"/>	Loss of balance	<input type="radio"/>	<input type="radio"/>	Skin conditions	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	Low back pain	<input type="radio"/>	<input type="radio"/>	Sleeping problems	<input type="radio"/>	<input type="radio"/>
Difficulty focusing	<input type="radio"/>	<input type="radio"/>	Low energy/tired	<input type="radio"/>	<input type="radio"/>	TMJ (Jaw tension)	<input type="radio"/>	<input type="radio"/>
Digestion problems	<input type="radio"/>	<input type="radio"/>	Menstrual irregularity	<input type="radio"/>	<input type="radio"/>	Tension	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	Menstrual pain	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>
Earaches	<input type="radio"/>	<input type="radio"/>	Mid back pain	<input type="radio"/>	<input type="radio"/>	Urinary problems	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	Mood swings	<input type="radio"/>	<input type="radio"/>			
Fever	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>			

Stress Survey

Do you notice you store your stress in:

- Neck/Shoulders Mid-back Low-back/pelvis Other _____

Please rate your GENERAL stress level, 0 to 10: _____ At work/school: _____ At home: _____

Please review each of these common stresses and write when you have experienced it in your life. Use **P** for **Past** and **C** for **Current**. If you expect or anticipate the possibility of experiencing this stress in the future use **F** for **Future**.

Physical

- ___ Bad posture
- ___ Broken bones
- ___ Falls of any type
- ___ Forceps delivery
- ___ Heavy lifting or bending
- ___ Overweight
- ___ Poor sleeping habits
- ___ Repetitive movements
- ___ Sports injuries
- ___ Strains or sprains
- ___ Other _____

Chemical

- ___ Consume alcohol
- ___ Diet with white flour & sugar
- ___ Eat fast foods
- ___ Environmental pollution
- ___ Overweight
- ___ Take over the counter drugs
- ___ Take prescription medication
- ___ Use artificial sweeteners
- ___ Use tobacco products
- ___ Other _____

Mental

- ___ Anger by you or at you
- ___ Death of loved one
- ___ Divorce of parents or spouse
- ___ Feel "not worthy"
- ___ Financial concerns
- ___ Put things off to the last-minute
- ___ Relationships
- ___ Serious illness (self or loved one)
- ___ Worry
- ___ Work environment
- ___ Other _____

Acknowledgment & Consent

Patients Name: _____ Date: ____/____/____