Living Life Chiropractic LLC

Adult Patient Questionnaire

Your first visit to our center is an opporunity 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/Partnered ◯ Widowed ◯ Divorced

Spouse/Partner'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 refering 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 sugeries and dates:

List any past accidents/injuries/falls and dates:

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

Quility of Life Inventory

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

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

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: ____/____/_____