Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

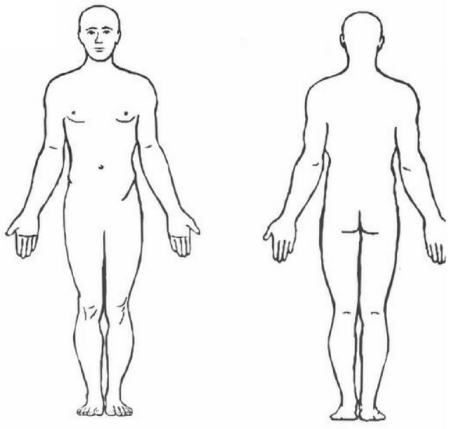
First Name:	**Last Name:**	**Date:**
Email:	**Mobile Number:**	**Birthday:**
Marital Status:	**# of Children:**	**Occupation:**
How did you hear about us?		
Stree Address:		**Height:**
City, State, Zip		**Weight:**
Emergency Contact:	**Emergency Relation:**	**Emergency Phone:**
Who is your primary care 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 the our office?
Have you received care for this problem before? Yes | No -if yes, please explain
When did this 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:

Your top three Health Goals:
1
2
3

"Medicine is the study of disease and what causes man to die. Chiropractic is the study of health and what causes man to live." - B.J. Palmer -

CHIROPRACTIC HISTORY

What would you like to gain from Chiopractic 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 speciality? __Pain Relief __Physical Therapy & Rehab __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:

Notalble childhood injuries? __Yes __No | If yes, please explain:

Youth or college sports? __Yes __No | If yes, list major injuries:

Any auto accidents? __Yes __No | If yes, please explain:

Exercise frequency? __None __1-2x per week __3-5x 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 socks/shoes, etc.)

How many hours per day you typically spend at a desk or on a computer, tablet, or phone?

TOXINS: Chemical & Environmental Exposure

Please rate/circle your CONSUMPTION for each:

1 = None | 3 = Moderate | 5 = High

Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweetners	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 & Challenges

Please rate/circle your STRESS for each:

1 = None | 3 = Moderate | 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 Name: _____ **Patient Signature:** _____ **Date:** _____

"Many of us take better care of our automobiles than we do our own bodies... yet the auto has replaceable parts." *- B.J. Palmer -*