ADULT NEW QUESTIONNAIRE

**Please fill out as thoroughly as possible as this will help us to serve you optimally **

CONFIDENTIAL PATIENT INFORMATION

First Name: Last Name: MI:

Nickname: DOB: / / Age: Sex: M F

Marital Status: # of children (if any) Occupation:

Street Address: Height ft in

City: State: Zip Weight lbs

Email: Cell phone: - - Other phone: - -

Emergency contact Emergency relation: Emergency phone: - -

How did you hear about us?
(if you were referred by someone please let us know)

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:

Race: Ethnicity: ☐ choose not to specify

Preferred language: ☐ English ☐ Spanish ☐ Sign lang ☐ other

Verification question: Mothers maiden name (first) (last)

Please note any significant <u>family medical history</u>:

Has any doctor diagnosed you with diabetes presently? Yes No
-If yes please specify Type 1 Type II Last blood lab test A1C >9.0% ? yes no unsure

WOMEN ONLY: Are you pregnant? Yes No ** if yes please notify us as there are additional questions
If yes, how far along are you?

YOUR HEALTH GOALS:

Your top three health goals: (be specific! 😊 These can be from pain relief to healthier lifestyle, etc

1. _____
2. _____
3. _____

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
Explain:

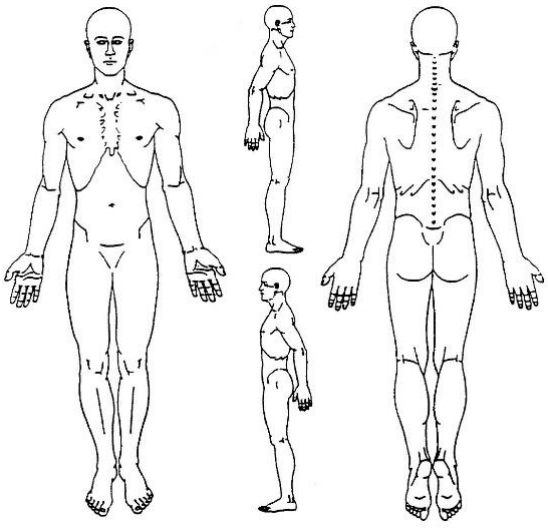
Is this condition getting worse improving intermittent constant unsure other:

What makes the problem better?:

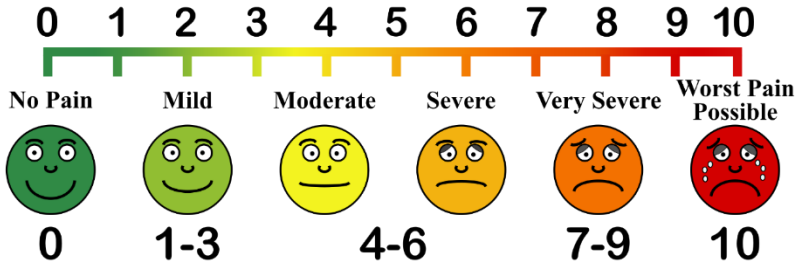
What makes the problem worse?:

Have you had an X-ray, CT scan, MRI or other imaging of your SPINE in the past year? Yes no
If yes please specify the date, region, and type of imaging taken
Date: / / Region: xray MRI CT other

Place an " X " on the drawings to the left wherever you have pain. Mark an "O" for past conditions or issues.



Please rate your pain level(s). Indicate for what region if multiple affected.



Any Radiation of pain (does it travel anywhere?)

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 ☐ 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, 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 shoes/socks, etc)

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

TOXINS: Chemical and 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/tobacco	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 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

*** I certify that the information provided is accurate to the best of my knowledge:**

Today's Date: ____/____/____ Printed name of patient: _____

Signature of Patient/legal guardian:_____