Adult Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: ○ M ○ F ○ Other SS #: _____

Marital Status: ○ S ○ M ○ D ○ W # of Children: _____

Occupation: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Height: _____

Weight: _____ Email: _____

Cell Phone: _____ Other Phone: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

2. How did you hear about us?

☐ Current Patient (List who) _____

☐ Professional Referral/Doctor (List who) _____

☐ Google Search _____

☐ Facebook _____

☐ Community Partner (List who) _____

☐ Other (Specify) _____

3. Who is you primary care physician?

_____ Date of your last visit: _____

Reason for your last doctor visit: _____

4. Are you also receiving care from any other health professionals?

○ Yes ○ No

5. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

6. Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

7. What health condition(s) bring you into our office?

8. Have you received care for this problem before?

- ○ Yes
- ○ No

9. If yes, please explain:

10. When did the condition(s) first begin?

11. How did the problem start?

- ○ Suddenly
- ○ Gradually
- ○ Post-Injury

12. Is this condition:

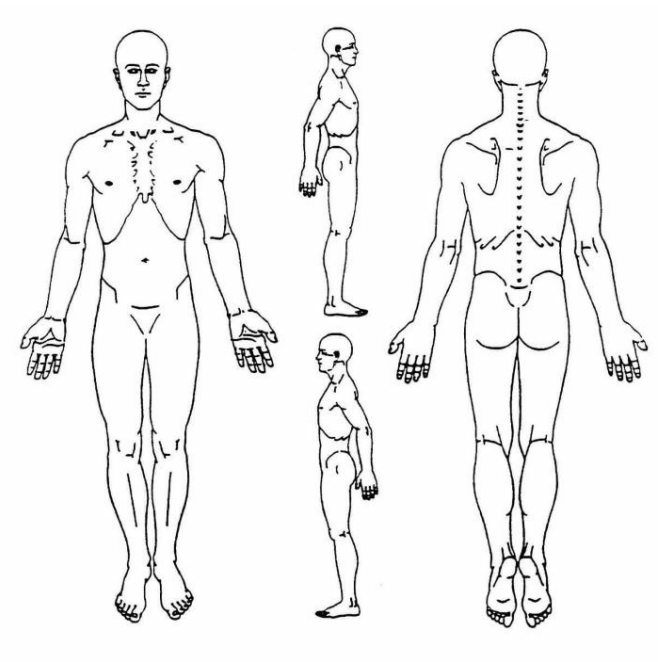
- ○ Getting worse
- ○ Improving
- ○ Intermittent
- ○ Constant
- ○ Unsure

13. What makes the problem better?

What makes the problem worse?

14. Please indicate where you are experiencing pain or discomfort.

0 - Painful 1 - Tender 2 - Sharp 3 - Ache 4 - Numbness/Tingling



YOUR HEALTH GOALS

15. Your top three health goals:

1.

2.

3.

CHIROPRACTIC HISTORY

16. What would you like to gain from chiropractic care?

○ Resolve existing condition(s) ○ Overall wellness ○ Both

17. Have you ever visited a chiropractor?

○ Yes ○ No

If yes, what is their name?

18. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

_____

19. Do you have any health concerns for other family members today?

_____

_____

_____

_____

TRAUMAS: Physical Injury History

20. Have you ever had any significant falls, surgeries or other injuries as an adult?

- ○ Yes
- ○ No

21. If yes, please explain:

_____

_____

_____

_____

22. Notable childhood injuries?

- ○ Yes
- ○ No

23. If yes, please explain:

_____

_____

_____

_____

24. Youth or college sports?

- ○ Yes
- ○ No

25. If yes, list major injuries:

_____

_____

_____

_____

26. Any auto accidents?

○ Yes ○ No

27. If yes, please explain:

_____

_____

_____

_____

28. Do you have an open claim in regard to an accident?

○ Yes ○ No ○ Not yet, but I plan to.

○ Unsure

29. Exercise Frequency?

○ None ○ 1-2x per week ○ 3-5x per week ○ Daily

What types of exercise?

_____

30. How do you normally sleep?

○ Back ○ Side ○ Stomach

31. Do you wake up:

○ Refreshed and ready ○ Stiff and tired

32. Do you commute to work?

○ Yes ○ No

If yes, how many minutes per day?

_____

33. List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

_____

_____

_____

_____

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

_____

TOXINS: Chemical & Environmental Exposure

35. Please rate your CONSUMPTION for each:

	None - 1	2	Moderate - 3	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

36. Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

THOUGHTS: Emotional Stresses & Challenges

37. Please rate your STRESS for each:

	None - 1	2	Moderate - 3	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

38. Are there other emotional stresses or challenges you'd like to tell us about?

_____

Patient Review of Systems

Below you will find 5 different sections with various conditions, symptoms or states of your system.

Please **CHECK** all boxes currently most associated with your health right **NOW,** or you have had in the **PAST**.

Your doctor will then use this in conjunction with the additional assessment testing to determine the type of care needed to serve you best.

39. Section 1

- ☐ High Energy
- ☐ Mentally Alert
- ☐ Few Symptoms
- ☐ Excellent Health
- ☐ Resistant to Infection
- ☐ Positive Mental Attitude
- ☐ Active
- ☐ Vibrant
- ☐ Not Applicable

40. Section 2

- ☐ Poor Attention
- ☐ Constipation
- ☐ Poor Concentration
- ☐ Lacking Motivation
- ☐ Spaciness
- ☐ Low Pain Threshold
- ☐ Depressed
- ☐ Worry
- ☐ Impulsive
- ☐ Disorganized
- ☐ Irritable
- ☐ Low Energy
- ☐ Easily Distracted
- ☐ Difficulty Walking
- ☐ Not Applicable

41. Section 3

- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Racing Mind
- ☐ Irritable Bowel
- ☐ Poor Expression of Emotions
- ☐ High Blood Pressure
- ☐ Heart Palpitations
- ☐ Restless Sleep
- ☐ Poor Immune System
- ☐ Accelerated Aging
- ☐ Tight Muscles
- ☐ Teeth Grinding
- ☐ Anxious
- ☐ Not Applicable

42. Section 4

- ☐ Migraines
- ☐ Bipolar Disorder
- ☐ Seizures
- ☐ PMS
- ☐ Bed Wetting/Bladder Issues
- ☐ Eating Disorder
- ☐ Headaches
- ☐ Mood Swings
- ☐ Sleepwalking
- ☐ Food Sensitivities
- ☐ Panic Attacks
- ☐ Hot Flashes
- ☐ Not Applicable

43. Section 5

- ☐ Cancer
- ☐ ALS
- ☐ Rheumatoid Arthritis
- ☐ Esptein-Barr Syndrome
- ☐ Multiple Sclerosis
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Autoimmune Disease

☐ Chronic Fatigue Syndrome ☐ Not Applicable

The TRUTH: The Disease Process *90-95% of disease is due to STRESS (not genetics) *Pre-birth brain controlled the development of EVERY SYSTEM *Post-birth brain controls and coordinates EVERY FUNCTION in your body *The longer the dysfunction, the more severe the disease (earliest correction is BEST) *The brain should be able to "fix" any issue IF it can communicate properly *STRESS affects the brain's ability to communicate properly *Poor brain function equals poor body function leading to symptoms and disease By signing below, I am agreeing that I have read the information presented above.

_____

Signature

Stress Scale for Adults

Below is a list of stressors that adults can experience during their life, and will impact their health. Beside each stress, you will see a number listed. That is called a "Life Change Unit". Please write the value listed in "Life Change Units" for each of the stressors you have experienced in the past, or are experiencing currently. The **total sum** of life change units will help the doctors and team to have a rough estimate on how greatly your stressors are affecting your life.

44.

Life Event - Life Change Unit	My Score
Death of a Spouse - 100	
Divorce - 73	
Marital Separation - 65	
Death of a close family member - 63	
Personal Injury or Illness - 53	
Marriage - 50	
Dismissal from work - 47	
Marital Reconciliation - 45	
Retirement - 45	
Change in health of Family Member - 44	
Pregnancy - 40	
Sexual Difficulties - 39	
Gain a new family member - 39	
Business Readjustment - 39	
Change in Financial State - 38	
Death of a close friend - 37	
Change to different line of work - 36	
Change in frequency of arguments - 35	

Major Mortgage - 32	
Foreclosure of mortgage or loan - 30	
Change in responsibilities at work - 29	
Child leaving home - 29	
Trouble with in-laws - 29	
Outstanding personal achievement - 28	
Spouse starts or stops work - 26	
Beginning or end of school - 26	
Change in living conditions - 25	
Revision of personal habits - 24	
Trouble with boss - 23	
Change in working hours or conditions - 25	
Change in residence - 20	
Change in schools - 20	
Change in recreation - 19	
Change in church activities - 19	
Change in social activities - 18	
Minor mortgage or loan - 17	
Change in sleeping habits - 16	
Change in number of family reunions - 15	
Change in eating habits - 15	
Vacation - 13	
Major Holiday - 12	
Minor violation of law - 11	

What is your total score?

What does that score mean?

Score of 300+: At risk of illness

Score of 150-299: Risk of illness is moderate (reduced by 30% from the above risk)

Score of 150 or less: Only a slight risk of illness

45. Please answer below if you DO or DO NOT allow your image (photographs and/or videos) or likeness to be used in Media publications including, but not limited to: Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

○ Yes, I DO consent ○ No, I DO NOT consent

ACKNOWLEDGEMENT & CONSENT

_____

Signature