PRAIRIE CHIROPRACTIC
REACTIVATION QUESTIONNAIRE

(PLEASE PRINT)

Date_____ **DOB**_____

Full Legal Name_____Jr./Sr.
First Middle Last

Cell Phone _____ **Home Phone** _____ **Preferred: Home or Cell**

Email Address _____

_____

Current Prescription Medications ☐ None

Name of Prescription

_____ _____ _____ _____

_____ _____ _____ _____

_____

HISTORY OF PRESENTING ILLNESS/INJURY:

What are your symptoms? List symptoms in order of importance.

1)_____
Date symptom began_____ **Work/ Auto-related?** ☐ No ☐Yes
How did it occur?_____
_____

2)_____
Date symptom began_____ **Work/ Auto-related?** ☐ No ☐ Yes
How did it occur?_____
_____

What makes condition better?_____

What makes condition worse?_____

Have you seen another provider for your symptoms?_____

Have you had any new traumas, surgeries, illnesses or medical diagnoses since your last visit? ☐ No ☐ Yes

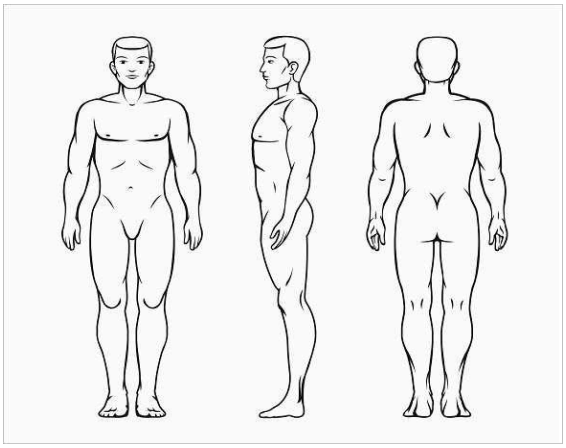
_____

_____

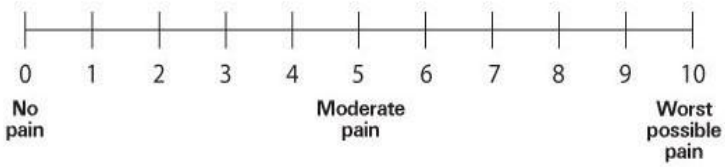
Are you pregnant? ☐ No ☐ Yes

Do you have new x-rays for these issues? ☐ No ☐ Yes

Place an "X" on symptomatic areas.



Rate each spot on the pain scale.



SOCIAL HEALTH HISTORY

List Social Health History changes since last visit which includes occupation, activity level, recreational activities/hobbies, dietary/water/caffeine/alcohol/smoking status? ☐ None

_____

_____

FAMILY HEALTH HISTORY

List health condition changes of family members since your last visit. ☐ No changes

_____

_____

SYSTEM REVIEW

Any changes with the following since last visit?

1.____Eyes (Glasses, Contacts, Cataracts, Glaucoma, etc.)
2.____Ears, Mouth, Nose, Throat (Hearing Loss, Sinus, etc.)
3.____Cardiovascular (Heart, High B.P., High Cholesterol, etc.)
4.____Respiratory (Lungs, Breathing, Asthma, COPD, etc.)
5.____Neurological (Nerve Issues, Weakness, Numbness, etc.)
6.____Endocrine (Thyroid, Hormonal Imbalance, Liver, etc.)
7.____Gastro-Intestinal (Acid Reflux, Ulcers, Gallbladder, IBS, etc.)
8.____Genito-Urinary (Male/Female Reproduction, Kidneys Bladder, etc.)
9.____Musculoskeletal (Breaks, Arthritis, Osteoporosis, Disc Injury, etc.)
10.____Skin (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, etc.)
11.____Psychiatric (Anxiety, Depression, Bipolar, ADD/ADHD, etc.)
12.____Other:_____

_____

My signature is an acknowledgement that all of the above statements are true. I hereby authorize Dr. Jennifer Kolander to examine and treat my condition as she deems appropriate through the use of Chiropractic care and I give authority for these procedures to be performed.

PATIENT SIGNATURE:_____ DATE:_____

GUARDIAN SIGNATURE:_____ DATE:_____

D.C. SIGNATURE:_____ DATE:_____