PRAIRIE CHIROPRACTIC
NEW PATIENT QUESTIONNAIRE AGES 11 AND UP

(PLEASE PRINT)

Date_____ **DOB**_____

Full LEGAL Name_____Jr./Sr.
First Middle Last

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

Email Address _____

Emergency Contact _____Phone_____ Relationship _____

How did you hear about our office?_____

Smoking Status ☐ Never ☐ Smoker
☐ Smoker- Daily (_____packs/day or _____cigarettes/day – for _____ years)
☐ Smoker- NOT Daily

Current Prescription Medications ☐ None **OR** ☐ See List Below

Name of Prescription

_____ _____ _____

_____ _____ _____

_____ _____ _____

HISTORY OF PRESENTING ILLNESS/INJURY

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

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

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

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

Do you have recent X-rays of the area(s)? ☐ No ☐ Yes

Facility where taken_____

HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S) *(see also page 1)*

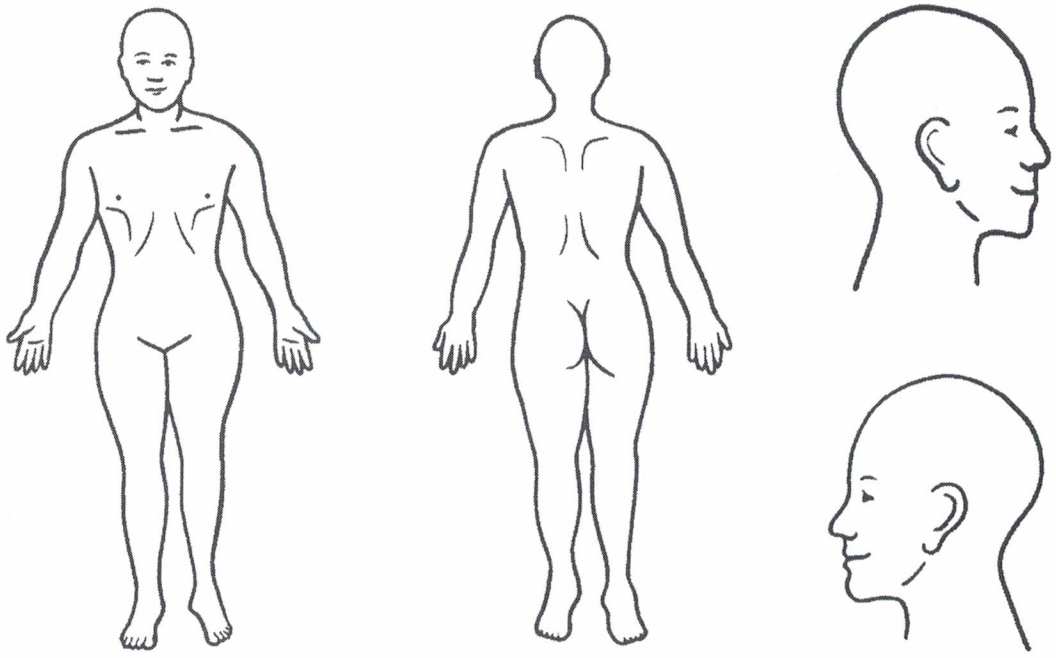
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 100 (0 = no pain; 100 = intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

X X X Burning Pain
(((Aching Pain
0 0 0 Pins & Needles
- - - -Numbness
: : : Sharp Pain

__ Constant
__ Comes/Goes

__ Getting Better
__ Getting Worse
__ Staying Same

Better: **Worse:**
___ AM ___
___ MID-DAY ___
___ PM ___



NO PAIN **PAIN SCALE:** **INTOLERABLE**

0___ 5___ 10___ 15___ 20___ 25___ 30___ 35___ 40___ 45___ 50___ 55___ 60___ 65___ 70___ 75___ 80___ 85___ 90___ 95___ 100

What Makes Condition BETTER?

Head / Neck:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:_____
Mid Back:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:_____
Low Back:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:_____
Shoulder, Arm, Wrist, Hand:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:_____
Hip, Leg, Ankle, Foot:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:_____
Other: _____	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:_____

What Makes Condition WORSE?

Head / Neck: _____
Mid Back: _____
Low Back: _____
Shoulder, Arm, Wrist, Hand: _____
Hip, Leg, Ankle, Foot: _____
Other: _____ _____

Indicate your Ability to Perform the Following Activities of Daily Living. Please use the following codes:
U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

___ Lying on Back	___ Dressing Self	___Lifting	___Kneeling	___ Twist/Turn – LEFT / RIGHT
___ Lying on Sides	___ Stooping	___Gripping	___Bending Forward	___ Sitting/Driving/Riding
___ Lying on Stomach	___ Pushing/Pulling	___Standing	___Get In/Out of Car	___ Using Computer
___Turning Over in Bed	___ Reaching	___Walking	___Sexual Activity	___ Using Stairs

___ Cough/Sneeze/Grunt – (if painful, where _____)

___ Sleeping - (# times wake up _____ ; # pillows _____; position sleep in: _____)

PAST MEDICAL HISTORY *(see also page 1)*

FEMALES: Are You Pregnant? ☐ No ☐ Yes – Due Date:_____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

MALES: Date of Last Prostate & Testicular Exam: _____

How often have you had this condition that you are seeing us today for? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Have you received care from a Chiropractor before? ☐ No ☐ Yes ***(see also page 1)***

Have you seen a Medical Doctor for this Condition? ☐ No ☐ Yes – Doctor/Clinic _____

Do you have any other Health Conditions? (Check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer

☐ Arthritis ☐ Infertility Issues ☐ Other: _____

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries:

DATE	DOCTOR	CONDITION(S)	RESULTS
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications

SOCIAL HEALTH HISTORY

Student ☐ Part-Time ☐ Full-Time ☐ N/A ***(see also page 1)***

Occupation _____ Hrs per Week_____

Recreational Activities/Hobbies_____

Do you Exercise? ☐ No ☐ Yes – How Often? _____ In What Way?_____

Do you consume Caffeine? ☐ No ☐ Yes – How Much? _____ How Often?_____

Do you consume Alcohol? ☐ No ☐ Yes – How Much? _____ How Often?_____

FAMILY HEALTH HISTORY

List any current or past health conditions of your family members (if deceased, indicate at what age and from what?)

MOTHER:_____

FATHER:_____

BROTHERS: _____How Many_____

SISTERS: _____How Many_____

CHILDREN: _____How Many_____

SYSTEM REVIEW QUESTIONS

Have you had any problems with the following areas Now or in the Past? (**Y** = Yes and **N** = No)

___**Eyes** (Glasses, Contacts, Cataracts, Glaucoma, Etc)

___**Ears, Mouth, Nose, Throat** (Hearing Loss, Sinus, Etc)

___**Cardiovascular** (Heart, High BP, High Cholesterol, Etc)

___**Respiratory** (Lungs, Breathing, Asthma, COPD, Etc)

___**Neurological** (Nerve Issues, Weakness, Numbness, Etc)

___**Endocrine** (Thyroid, Hormonal, Imbalances, Liver, Etc)

___**Gastro-Intestinal** (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc)

___**Genito-Urinary** (Male/Female Reproductive, Kidney, Bladder, Etc)

___**Musculoskeletal** (Breaks, Arthritis, Osteoporosis, Discs, Etc)

___**Skin** (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc)

___**Psychiatric** (Anxiety, Depression, Bipolar, ADD/ADHD, Etc)

___**Others:** _____

Please describe in more detail: _____

NOTES