Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
Street Address:		Height:
City, State, Postal Code:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit?

Are you 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 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

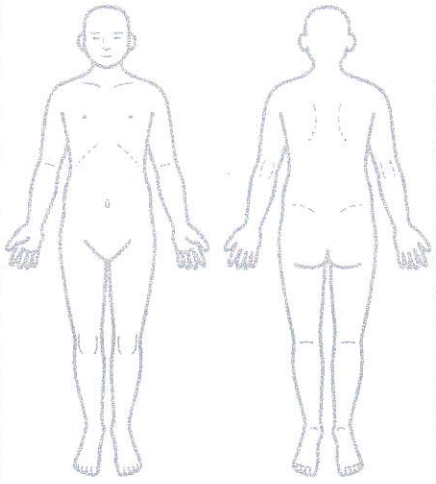
Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

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

What are your top three health goals?

1. _____

2. _____

3. _____

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 ○ Nutrition ○ 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 past auto accidents? ○ Yes ○ No – If yes, please explain:

How often do you exercise? ○ None ○ 1-3x per week ○ 4-6x 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? On a computer, tablet or phone?

TOXINS: Chemical & 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	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 or 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

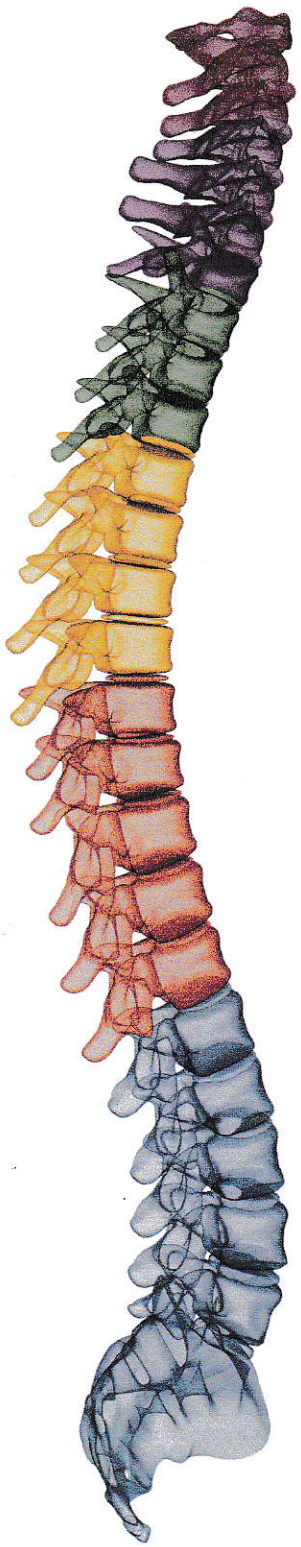
Acknowledgement & Consent

Patient Signature: _____ Date: _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		PAST PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	☐ ☐ Epilepsy & Seizures
		☐	☐	Ear & Sinus Infections	☐ ☐ Sensory & Spectrum
		☐	☐	Allergies & Congestion	☐ ☐ ADD / ADHD
		☐	☐	Immune Deficiency	☐ ☐ Focus & Memory Issues
		☐	☐	Headaches & Migraines	☐ ☐ Anxiety & Stress
		☐	☐	Vertigo & Dizziness	☐ ☐ Balance & Coordination
		☐	☐	Sore Throat & Strep	☐ ☐ Speech Issues
		☐	☐	Swollen Tonsils & Adenoids	☐ ☐ TMJ / Jaw Pain
		☐	☐	Vision & Hearing Issues	☐ ☐ Stiff Neck & Shoulders
		☐	☐	Low Energy & Fatigue	☐ ☐ Depression
		☐	☐	Difficulty Sleeping	☐ ☐ High Blood Pressure
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	☐ ☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	☐ ☐ Bronchitis & Pneumonia
		☐	☐	Chronic Colds & Cough	☐ ☐ Functional Heart Conditions
		☐	☐	Asthma	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	☐ ☐ Indigestion & Heartburn
		☐	☐	Jaundice	☐ ☐ Stomach Pains & Ulcers
		☐	☐	Fever	☐ ☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	☐ ☐ Allergies & Eczema
		☐	☐	Hyperactivity	☐ ☐ Skin Conditions / Rash
		☐	☐	Chronic Fatigue	☐ ☐ Kidney Problems
		☐	☐	Chronic Stress	☐ ☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	☐ ☐ Sciatica & Radiating Pain
		☐	☐	Chrohn's, Colitis & IBS	☐ ☐ Lumbopelvic / SI Joint Pain
		☐	☐	Diarrhea	☐ ☐ Hamstring Tightness
		☐	☐	Bed-wetting	☐ ☐ Disc Degeneration
		☐	☐	Bladder & Urination Issues	☐ ☐ Leg Weakness & Cramps
		☐	☐	Cramps & Menstrual Issues	☐ ☐ Poor Circulation & Cold Feet
		☐	☐	Cysts & Endometriosis	☐ ☐ Knee, Ankle & Foot Pain
		☐	☐	Infertility	☐ ☐ Weak Ankles & Arches
		☐	☐	Impotency	☐ ☐ Lower Back Pain
		☐	☐	Hemorrhoids	☐ ☐ Gluten & Casein Intolerance

Patient Name: _____ Date: _____

Your Chiropractic Care Goals

How is your condition interfering with YOUR LIFE?(Examples: Can't Sit 30 min +, Can't lift Grandchild)

Please check the option that best describes what you are looking for so we can create a care plan that honours your choices and supports the level of care you feel is right for you:

☐1. Band-Aid / Symptom Relief Care

I am mainly looking for relief from my current symptoms. My goal is to feel better and get back to my normal activities as quickly as possible.

The focus is on reducing pain and discomfort so you can return to normal activities as quickly as possible.

Typical timeframe: Approximately 6–8 weeks of care focused on symptom relief.

This option focuses on short-term relief rather than correcting the underlying cause.

☐2. Corrective Care

I understand that symptoms are often warning signs of a deeper issue. I would like to correct the underlying problem as thoroughly and professionally as possible, not just relieve symptoms.

The Focus is fixing the cause. You want lasting change and peace of mind knowing their spine and nervous system are functioning properly.

Typical timeframe: Approximately 9–18 months, depending on individual findings and history.

This option focuses on structural correction and long-term improvement.

☐3. Wellness Care

I value a properly functioning nervous system and want to maintain my health long-term. I am interested in ongoing chiropractic care to support optimal function and prevention for myself and/or my family.

The focus is regular chiropractic care as part of your long-term health and prevention strategy.

Typical timeframe: Ongoing Lifetime care based on individual goals and lifestyle.

This option focuses on maintaining optimal function and proactive health.

INFORMED CONSENT TO EXAMINATION & X-RAY:

I hereby request and consent to the performance of a Chiropractic, Orthopaedic and Neurological examination and diagnostic x-rays (if required) which will determine if Chiropractic can help me. I understand that in some cases, the examination may aggravate my present condition.

Name: _____ Signature: _____

(please print)

Date: _____

FOR WOMEN ONLY:

Date of last period? _____ Are you pregnant? YES NO MAYBE

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, custom foot orthotics or subsequent diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatments, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent for chiropractic adjustments and care. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW,

I AGREE TO THE ABOVE NAMED PROCEDURES.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

PATIENT'S NAME (please print) SIGNATURE OF PATIENT (or parent/guardian)

_____ _____

DATE WITNESS TO SIGNATURE ABOVE

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