Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS #:	DOB:	Sex: ◯ M ◯ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		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:

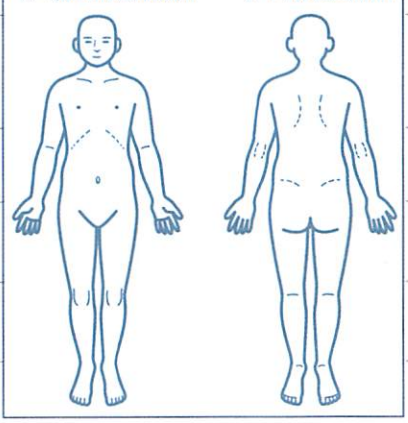
Are you also receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

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

Please indicate where you are experiencing pain or discomfort.
X= Current condition O= Past condition



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?

YOUR HEALTH GOALS

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 ◯ 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 ◯ 3-6x 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 you typically spend sitting at a desk or 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 & Sweets	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/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

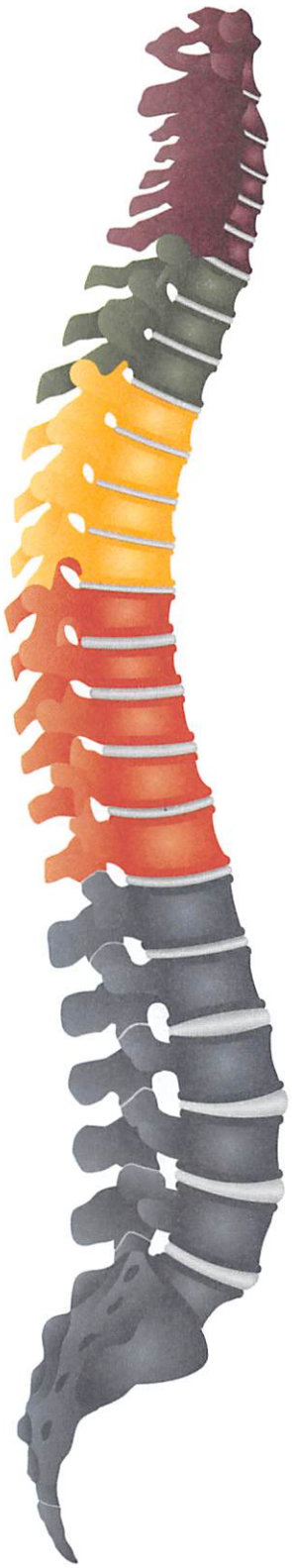
ACKNOWLEDGMENT & CONSENT

Patient Name: _____ 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 _____

What to Expect

Today's Visit:

- Consultation
- History
- Examination
- X-rays (if necessary)

Follow up Visit:

- Review of the X-rays and/ or examination findings
- Review of health concepts (function)
- Begin treatment
- Meet with treatment coordinator

After your treatment:

Avoid turning your head for a minimum of **20 minutes**. Your body may want to revert to patterns that are not healthy.

Drink plenty of water. Some tend to detoxify after receiving their initial treatment. Water helps to hydrate muscles and assist the body in the detoxification process.

Don't be alarmed if your body **clicks, pops,** or **feels mildly sore** in the days following an adjustment. These changes are signs that your body is responding to treatment.

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Finnigan Clinic will prepare any necessary reports and forms to assist me in collecting from the insurance company. Any amount authorized to be paid directly to Finnigan Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me will be my personal responsibility. I also understand that if I suspend or terminate my care and treatment, any fees for professional services, including X-Rays taken at this office at $55.00 per view, will become immediately due and paid in full. Fee schedules are available.

Patient's Signature_____ Date_____

Guardian or Spouse's Signature_____Date_____

Physician's Signature_____Date_____

We look forward to working with you!