

# Adult Patient Questionnaire

## Confidential Patient Information

First Name:	Last Name:	Date:
SSN:	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? <input type="radio"/> Yes <input type="radio"/> 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:

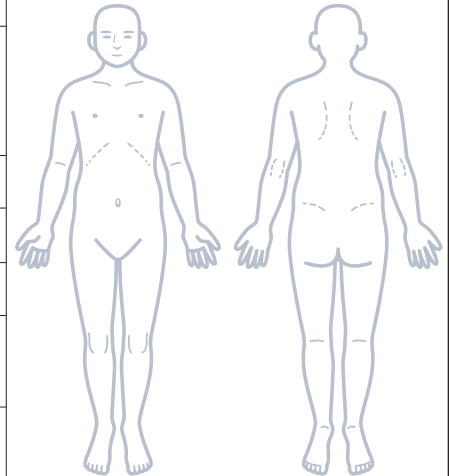
When did the condition(s) first begin?

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

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				
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				
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: \_\_\_\_\_

### All Star Family Chiropractic

2640 S. Cleveland Ave., Saint Joseph, MI | 269-201-5400  
drsandy@allstarfamilychiropractic.com | AllStarFamilyChiropractic.com