# Adult Patient Questionnaire

**Confidential Patient Information**

Legal First Name: _____ MI: _____ Legal Last Name: _____

Date of Birth: _____ Sex: M or F Marital Status: Single Married Engaged Divorced Widowed Other

Street Address: _____

City, State, Zip Code: _____ Email Address: _____

Phone Number: _____ Type of Phone Number: Cell Home Work

Do you want appointment reminders via Text? Y or N Number of Children: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone #: _____

Primary Care Physician: _____ Do you get annual physicals: Y or N

Any significant family medical history (mom, dad, brothers, sisters, grandmas or grandpas: Y or N

If Y, who and what condition did they have: _____

_____

---

**Current Health Conditions**

What condition(s) bring you into our office? Please list in order of importance.

1. _____ When did symptoms begin? _____ How did it start? _____
2. _____ When did symptoms begin? _____ How did it start? _____
3. _____ When did symptoms begin? _____ How did it start? _____

Have you had issues in any of these areas prior to today's visit? Y or N

If Y, Condition number (from above) and when have you experienced the same issues in the past?

_____

Was this condition caused by a work accident or motor vehicle accident? Y or N Is there an open case for the injury? Y or N

What makes the condition feel better? _____ What makes the condition feel worse? _____

Describe type of pain caused: Aching Sharp Burning Numbness Tingling Stiffness Soreness Pins & Needles

Are there specific activities that this condition keeps you from doing? _____

On a pain scale from 0 (no pain) to 10 (worst pain that you can imagine) please rate below:

When feeling your best: _____ When feeling your worst: _____ Current pain scale: _____

Is there ANY chance that you could be pregnant? Y or N If Y - Due Date: _____

**Past Health History**

Have you seen a chiropractor in the past? Y or N Were you treated using the chiropractors: hands or using a tool? (Circle One or both)

Were there any therapies used? (circle one or more if yes) Ultrasound, Electric Muscle Stimulation, Laser, Therapeutic Exercises, Decompression Therapy, Other _____

Have you ever had any previous accidents, slips, or falls resulting in injury? Please include type of accident, year, and any injuries received in the accident.

1. _____
2. _____

How often do you exercise? Not at all 1-3 day per week 4-6 days per week Daily Working only

Type of exercise you do? _____

What position do you typically sleep in? On my Stomach On my Side On my Back

How much water do you drink per day in oz? _____ Cups of caffeinated drinks per day_____

Alcoholic beverages per week on average _____ Cigarettes/tobacco per day _____

Do you follow any special diets? _____ Any known allergies: _____

Please list all diagnosed conditions: _____

Do you have any history of cancers, seizures, strokes, high blood pressure, diabetes? _____

Current medications: _____

_____

Have you had any recent x-rays, CT scans, MRIs or other imaging? If Y list where and what was performed.

_____

**Surgeries**: ☐ **None** ☐ **See list below**

List any surgeries and approximate years performed: _____

_____

**Medical History** (Place an X in the box if you have or have had in the past any condition listed)

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Asthma | ☐ Back pain | ☐ Broken bones |
| ☐ Cancer | ☐ Chest pain | ☐ Anxiety/Depression | ☐ Diabetes |
| ☐ Dizziness | ☐ Epilepsy | ☐ Eye/vision trouble | ☐ Fainting |
| ☐ Fatigue | ☐ Genetic spinal disorder | ☐ Headaches | ☐ Hearing trouble |
| ☐ Heart attack | ☐ Hepatitis | ☐ High blood pressure | ☐ Jaw pain |
| ☐ Joint stiffness | ☐ Low back pain | ☐ Menstrual problems | ☐ Multiple Sclerosis |
| ☐ Neck pain | ☐ Neurological disorder | ☐ Pacemaker | ☐ Parkinson's Disease |
| ☐ Prostate problems | ☐ Significant weight change | ☐ Sleep Apnea | ☐ Spinal cord inj. |
| ☐ Sprain/strain | ☐ Stomach problems | ☐ Stroke | ☐ Tumor |
| ☐ Ulcer(s) | ☐ Other_____ | | ☐ **None of the above** |

**Acknowledgement & Consent**

**I, the undersigned, acknowledge that all of the above statements in this form are true to the best of my knowledge. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.**

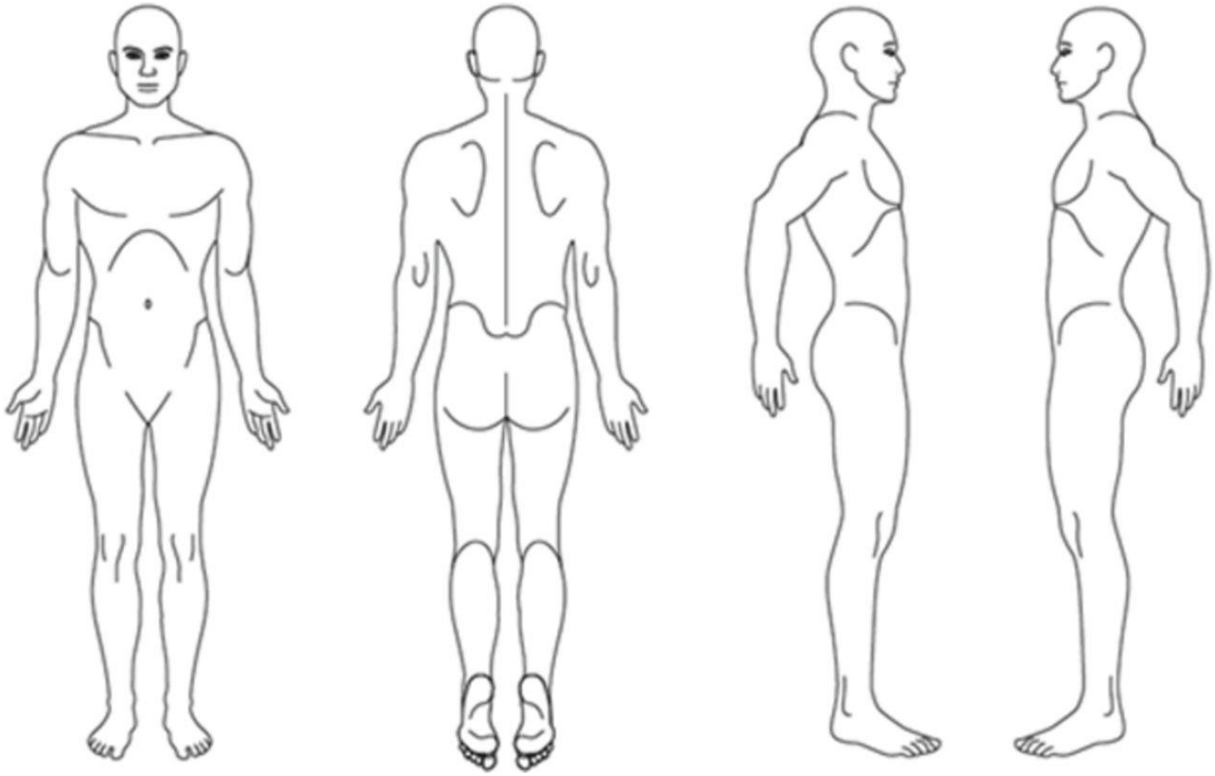
**Patient Signature _____ Date: _____**

# Pain Drawing

Name: _____ Date: _____

Use the following descriptive symbols on the image below to show the type of discomfort you are feeling and draw on the image as to where you are having the symptoms.

| Aches | Numbness | Burning | Stabbing | Pins & Needles | Stiffness | Other |
|---|---|---|---|---|---|---|
| ^^^ | ooo | xxx | /// | ….. | +++ | - - - |



Indicate on the line how severe your pain is by marking an "X" on the line

(0 = no pain, 1-4 is mild, 5-7 is moderate, 8-10 is severe)

Rate your neck pain. 0 _____ 10

Rate you back pain. 0 _____ 10

Rate your arm pain. 0 _____ 10

Rate your leg pain. 0 _____ 10