

Adult Patient Questionnaire



Big Beautiful Life
Chiropractic & Wellness

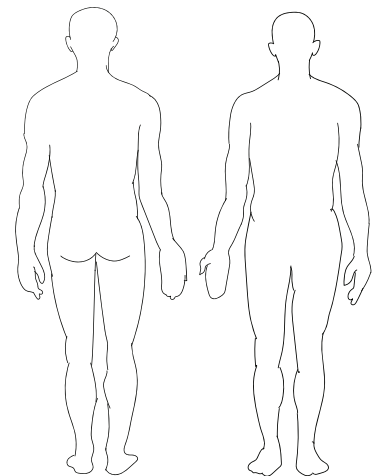
CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS#:	DOB:	Sex: <input type="radio"/> M <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, please name them and their specialty:</i>		
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? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, please explain:</i>
When did the condition(s) first begin?
How did the problem start? <input type="radio"/> Suddenly <input type="radio"/> Gradually <input type="radio"/> Post-Injury
Is this condition: <input type="radio"/> Getting Worse <input type="radio"/> Improving <input type="radio"/> Intermittent <input type="radio"/> Constant <input type="radio"/> Unsure
What makes the problem better?
What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.



Mark an "X" for Current Condition(s)
Mark an "O" for Past Condition(s)

YOUR HEALTH GOALS

Your top three health goals:

- _____
- _____
- _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? Resolve existing conditions Overall wellness Both

Have you ever visited a chiropractor? Yes No

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/Ready Stiff/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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Processed Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugar & Sweets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sugary Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dairy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gluten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Recreational Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CURRENT MEDICINES AND SUPPLEMENTS

Please list any (prescription and non-prescription) medications/drugs you have taken in the past 6 months and why:

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

PAST HEALTH HISTORY

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Abnormal Heart Beats
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Nerve Pain
<input type="checkbox"/> Skin Issues	<input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

ACKNOWLEDGMENT & CONSENT

I consent to a professional and complete chiropractic examination and I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Patient Name: _____ Date: _____

Signature: _____