Adult Patient Questionnaire

Big Beautiful Life
Chiropractic & Wellness

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
	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?

Have you received care for this problem before? ◯ Yes ◯ No
If yes, please explain:

When did the condition(s) first begin?

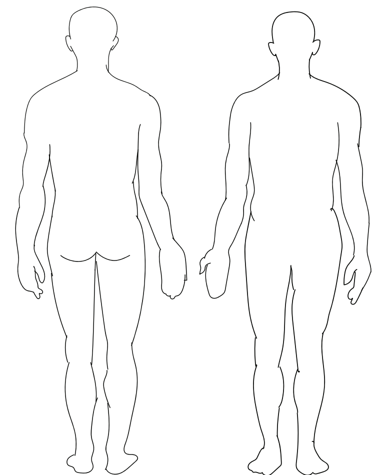
How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

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.



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

YOUR HEALTH GOALS

Your top three health goals:

1. ______________________________

2. ______________________________

3. ______________________________

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 was 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
Alcohol	◯	◯	◯	◯	◯
Water	◯	◯	◯	◯	◯
Sugar & Sweets	◯	◯	◯	◯	◯
Dairy	◯	◯	◯	◯	◯
Gluten	◯	◯	◯	◯	◯

	None		Moderate		High
Processed Foods	◯	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯	◯
Sugary Drinks	◯	◯	◯	◯	◯
Cigarettes	◯	◯	◯	◯	◯
Recreational Drugs	◯	◯	◯	◯	◯

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
Home	◯	◯	◯	◯	◯
Work	◯	◯	◯	◯	◯
Life	◯	◯	◯	◯	◯

	None		Moderate		High
Money	◯	◯	◯	◯	◯
Health	◯	◯	◯	◯	◯
Family	◯	◯	◯	◯	◯

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):

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