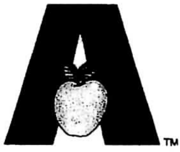

PATIENT QUESTIONNAIRE

(PLEASE PRINT)

New Patient ☐
Reactivate ☐
Other ☐

***Full Legal Name** ______________________________ ***Birth Date** __________
First *Middle* *Last*

***Address** ______________________________
Street / PO Box *City* *State* *Zip*

***Home Phone** __________ ***Mobile Phone** __________ **Fax** __________

Would you like to receive Email or Text reminders for appointments? ☐ No ☐ Yes – ***(*Please sign Authorization form at office)***

Employer** __________ ***Work Phone** __________ Student ☐ No ☐ Yes - ***(see also page 4)

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Email Address** __________

Spouse Name __________ Phone # __________ Spouse Employer __________

Emergency Contact __________ Phone # __________ Relationship __________

***Did anyone refer you to our office?** ☐ No ☐ Yes – Who __________

PATIENT DEMOGRAHICS *(*Required per Federal Guidelines)*

SSN# ______-______-______

***Gender** ☐ Male ☐ Female

***Ethnicity *(select one)*:** ☐ Hispanic ☐ Not Hispanic

***Race *(select one)*:**

☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White/Caucasian
☐ American Indian ☐ Black/African American ☐ Other Pacific Islander ☐ Other: __________

***Language *(select one)*:**

☐ English ☐ Hmong ☐ Lao ☐ Spanish ☐ Vietnamese ☐ Other: __________

How do you prefer to receive follow-up reminders for Preventive Care? *(select one) (see page 1)

☐ Letter ☐ Phone Call ☐ Email ☐ Fax

***Allergies:** ☐ None **-OR-** ☐ See List Below:

Drug/Medication (ADR):	***Food:***	***Other Allergies (e.g.-animals, pollen, latex, etc)***

***Smoking Status (Individuals age 13 years and older):**

☐ Smoker-Daily (___Packs/day or ___Cigarettes/day – for: ___Years or Since: ____/____/____)
☐ Smoker-Some Days (<u>NOT</u> Daily)
☐ Former (___Packs/day or ___Cigarettes/day – from: Age ____ to Age ____)
☐ Never
☐ Smoker-Current Status Unknown

***Current Prescription Medications** ☐ None **- OR -** ☐ See List Below

Name of Prescription:	*Dose (mg, mL, etc)*	*Form (Tab, Caps, etc)*	*Duration (# times per day, wk, mo)* **-AND-**	*Chronic*	*As Needed*	*Unknown*
			____x per______			
			____x per______			
			____x per______			
			____x per______			
			____x per______			

PAST MEDICAL HISTORY

FEMALES: Are You Pregnant? ☐ No ☐ Yes – Due Date:__________ Doctor: __________

Date of Last Gynecological & Breast Exam: __________

MALES: Date of Last Prostate & Testicular Exam: __________

How often have you had this condition that you are seeing us today for? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Have you received care from a Chiropractor before? ☐ No ☐ Yes

Have you seen a Medical Doctor for this Condition? ☐ No ☐ Yes – Doctor/Clinic __________

Do you have any other Health Conditions? (Check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer

☐ Arthritis ☐ Infertility Issues ☐ Other: __________

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries:

DATE	DOCTOR	CONDITION(S)	RESULTS
______	______	______	☐ Full Recovery ☐ Complications
______	______	______	☐ Full Recovery ☐ Complications
______	______	______	☐ Full Recovery ☐ Complications
______	______	______	☐ Full Recovery ☐ Complications
______	______	______	☐ Full Recovery ☐ Complications
______	______	______	☐ Full Recovery ☐ Complications

SOCIAL HEALTH HISTORY

Student ☐ Part-Time ☐ Full-Time ☐ N/A ***(see also page 1)***

Occupation __________ Hrs per Week_____

Recreational Activities/Hobbies__________

Do you Exercise? ☐ No ☐ Yes – How Often? __________ In What Way?__________

Do you consume Caffeine? ☐ No ☐ Yes – How Much? __________ How Often?__________

Do you consume Alcohol? ☐ No ☐ Yes – How Much? __________ How Often?__________

FAMILY HEALTH HISTORY

List any current or past health conditions of your family members (if deceased, indicate at what age and from what?)

MOTHER:__________

FATHER:__________

BROTHERS: __________How Many_____

SISTERS:__________How Many_____

CHILDREN: __________How Many_____

SYSTEM REVIEW QUESTIONS

Have you had any problems with the following areas Now or in the Past? (**Y** = Yes and **N** = No)

___**Eyes** (Glasses, Contacts, Cataracts, Glaucoma, Etc)

___**Ears, Mouth, Nose, Throat** (Hearing Loss, Sinus, Etc)

___**Cardiovascular** (Heart, High BP, High Cholesterol, Etc)

___**Respiratory** (Lungs, Breathing, Asthma, COPD, Etc)

___**Neurological** (Nerve Issues, Weakness, Numbness, Etc)

___**Endocrine** (Thyroid, Hormonal, Imbalances, Liver, Etc)

___**Gastro-Intestinal** (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc)

___**Genito-Urinary** (Male/Female Reproductive, Kidney, Bladder, Etc)

___**Musculoskeletal** (Breaks, Arthritis, Osteoporosis, Discs, Etc)

___**Skin** (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc)

___**Psychiatric** (Anxiety, Depression, Bipolar, ADD/ADHD, Etc)

___**Others:** __________

Please describe in more detail: __________

NOTES

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HISTORY OF PRESENTING ILLNESS/INJURY

***What are your symptoms?** ____________________

***Date your symptoms began?** ____________________

How did it occur?** ____________________ ☐ ***Work Related** ☐ ***Auto Accident** ***(*Provide copies of ALL Documents)

Have you missed any work? ☐ No ☐ Yes - How Much? ____________________ hours / days / weeks / months

***Do you have any recent X-rays of that area(s)?** ☐ No ☐ Yes – Facility where taken? ____________________

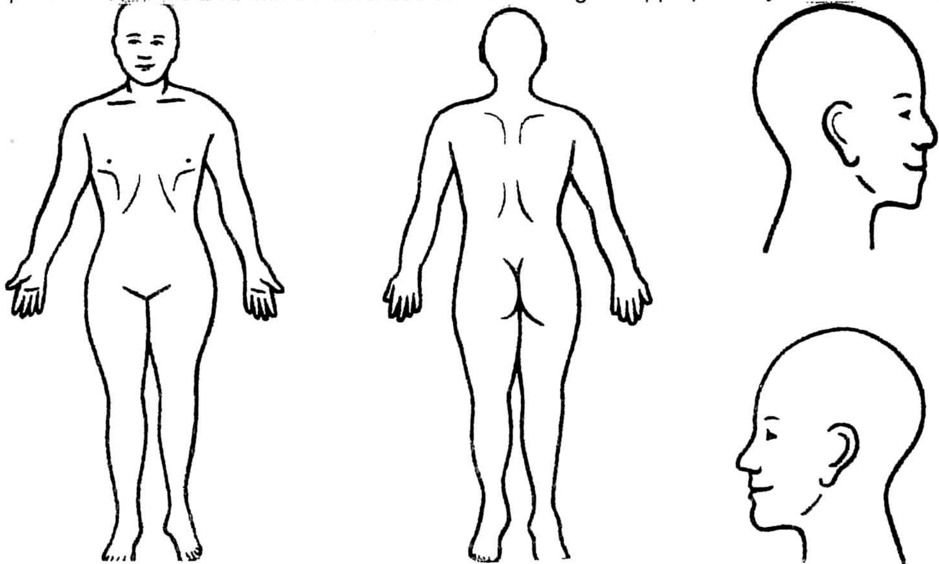
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left.

X X X Burning Pain
(((Aching Pain
0 0 0 Pins & Needles
- - - -Numbness
: : : Sharp Pain

__ Constant
__ Comes/Goes

__ Getting Better
__ Getting Worse
__ Staying Same

Better:		Worse:
__	AM	__
__	MID-DAY	__
__	PM	__



What Makes Condition BETTER?

Head / Neck:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other: ________
Mid Back:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other: ________
Low Back:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other: ________
Shoulder, Arm, Wrist, Hand:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other: ________
Hip, Leg, Ankle, Foot:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other: ________
Other: ________	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other: ________

What Makes Condition WORSE?

Head / Neck: ____________________

Mid Back: ____________________

Low Back: ____________________

Shoulder, Arm, Wrist, Hand: ____________________

Hip, Leg, Ankle, Foot: ____________________

Indicate your Ability to Perform the Following Activities of Daily Living. Please use the following codes:
U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

__ Lying on Back	__ Dressing Self	__Lifting	__Kneeling	__ Twist/Turn – LEFT / RIGHT
__ Lying on Sides	__ Stooping	__Gripping	__Bending Forward	__ Sitting/Driving/Riding
__ Lying on Stomach	__ Pushing/Pulling	__Standing	__Get In/Out of Car	__ Using Computer
__Turning Over in Bed	__ Reaching	__Walking	__Sexual Activity	__ Using Stairs

__ Cough/Sneeze/Grunt – (if painful, where ____________________)

__ Sleeping - (# times wake up ______ ; # pillows ______; position sleep in: ____________________)

CLINIC USE ONLY: ***(Vitals age 2 yrs+)***

Height ________ inches; Weight ________ lbs; Pulse ________ ; Respir ________ ; Temp ________ ;

Blood Pressure (Left Arm / Right Arm) ________/________ (Sitting / Standing / Supine) **Staff Initials:** ______