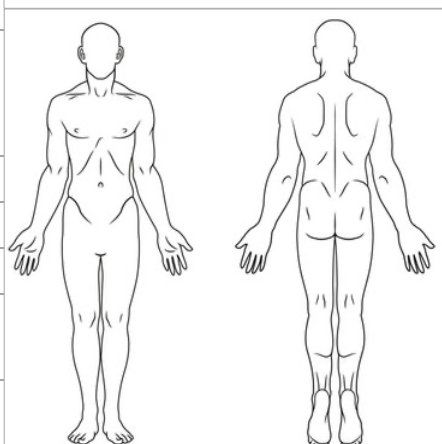


Adult Intake Questionnaire

CONFIDENTIAL PATIENT INFORMATION		
First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
Street Address:	Height:	
City, State, Postal Code:	Weight:	
Cell Phone:	Email:	
Emergency Contact:	Relation:	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?	<p>Please indicate where you are experiencing pain or discomfort.</p> 
Have you received care for this problem before? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	
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?	

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?

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?

Youth or college sports?

Any past auto accidents?

How often do you exercise?

What types of exercise?

How do you normally sleep?

Do you commute to work?

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		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	<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, etc. 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"/>

Acknowledgment & Consent

Signature: _____ Date: _____