

Name: _____ Date: _____ SS#: _____

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Address: _____ City: _____ State: ___ Zip: _____

Home phone: _____ Business phone: _____ Cell phone: _____

e-mail address: _____

Gender: Male Female Birth Date: _____ (mm/dd/yyyy) Age: _____

Employer: _____ Occupation: _____

Employment address: _____

In case of emergency:
Contact name: _____ Relationship: _____ Phone: _____

Referred by: _____

Have you ever been treated by a chiropractor before? Yes No

How would you describe your chief complaint at this time? _____

When did it start? _____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: Intermittent Constant

Have you had this problem in the past? Yes No If so, how often? _____

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How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate? _____

When you engage in the physical activity noted above, what is the average duration of activity?

- Less than 10 minutes
- 10 – 20 minutes
- 20 – 30 minutes
- 30 – 60 minutes
- over 60 minutes

When you engage in the physical activity noted above, what do you feel the level of effort is? _____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate? _____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

Is your pain the result of a motor vehicle accident? Yes No

- Have you filed a legal suit? Yes No

Is your pain the result of a work related injury? Yes No

- If so, have you filed a worker’s compensation claim? Yes No

Please list accidents, injuries, surgeries, and hospitalizations you have had:

Accident Type	Date	Age at time of accident

Name: _____ Date: _____ SS#: _____

Do you or other family members have a history of any of the following?

- | | | |
|----------------|-------------------------------|---------------------|
| Arthritis | <input type="checkbox"/> Self | Family member _____ |
| Asthma | <input type="checkbox"/> Self | Family member _____ |
| Diabetes | <input type="checkbox"/> Self | Family member _____ |
| Cancer | <input type="checkbox"/> Self | Family member _____ |
| Heart Disease | <input type="checkbox"/> Self | Family member _____ |
| Hypertension | <input type="checkbox"/> Self | Family member _____ |
| Hypoglycemia | <input type="checkbox"/> Self | Family member _____ |
| Kidney Disease | <input type="checkbox"/> Self | Family member _____ |
| Depression | <input type="checkbox"/> Self | Family member _____ |
| Mental Illness | <input type="checkbox"/> Self | Family member _____ |

- Do you drink coffee or black tea? Yes No If so, how much per day? _____
- Do you smoke tobacco? Yes No If so, how much per day? _____
- Do you drink alcohol? Yes No If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

Name	Reason

Please list any allergies that you have (food, drugs, other...): _____
