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Personal Data

Dear Patient, in our efforts to better serve you, please complete the following questionnaire and return it to the office. Thank you!

Name: _____ Today's Date: _____ DOB: _____ Age: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Phone: (home) _____ (work)_____ (cell)_____
Email Address: _____
Marital Status:
Name of Spouse/Partner: _____
Names and Ages of Children: _____
Occupation: _____ # of Hours per week currently working: _____
Spouse Occupation: _____ # of Hours per week currently working: _____
Who may we thank for referring you?: _____

Reason for Seeking Chiropractic Care

What has brought you here today? _____
In what ways do you feel our office can help you? _____
Have you ever received Chiropractic Care?
If so:

- When? _____
- How frequently? _____
- How long? _____
- Why did you Stop? _____

Does your immediate family, including kids, receive regular chiropractic care?

Stresses that affect the spine and nervous system may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the stresses that have acted upon your spine and nervous system assist us in serving you. With each of the following potential spinal stress situations, please fill out all that applies.

Physical Stress

Please describe the major physical traumas that you remember and when they happened, including:

- Accidents (as an adult or child): _____
- Surgeries/Hospitalizations: _____
- Physical Stress @ Work (sitting all day, lifting, etc):_____
- Physical Abuse: _____
- Major dental work such as braces: _____
- Other: _____

Emotional Stress

Please describe and give dates for any emotional stress related to:

- Relationships: _____
- Work or School : _____
- Loss of a loved one: _____
- Childhood trauma (divorce, abuse (verbal, sexual, emotional), bullying, deaths etc): _____
  _____
- Other: _____

Chemical Stress

List any drugs/medications (past or current) and reasons for taking them (including prescription and over the counter drugs) _____
_____

Do you eat refined, processed foods?
If yes, please explain: _____
Tobacco use?
Alcohol consumption? How much? _____

Women Only

Are your menstrual periods regular?
If not, please describe: _____
Do you currently or have you ever taken birth control pills? Reason? _____
Are you pregnant? If pregnant, due date: _____
Name of OBGYN/Midwife: _____

Current Lifestyle

Have you consulted or do you currently consult any of the following providers? (check all that apply):

(☐) Naturopath
(☐) Acupuncturist
(☐) Homeopath
(☐) Medical Physician
(☐) Bodywork/Massage
(☐) Psychotherapist
(☐) Dentist
(☐) Other: _____

Reason why: _____
Describe your current diet: _____
Water intake: _____ Exercise: _____ Sleep/Rest: _____
Work satisfaction: _____ Family Dynamic: _____
Do you have spiritual/awareness practice? (meditation, yoga, prayer, etc.)
If yes, please explain: _____
What is your ideal vision of yourself? _____
How is your present lifestyle affecting this vision of yourself? _____
What changes are you willing to make? _____
What is your #1 priority in life? _____
What else would you like to share with us about your life? _____

Signature: _____ Date: _____