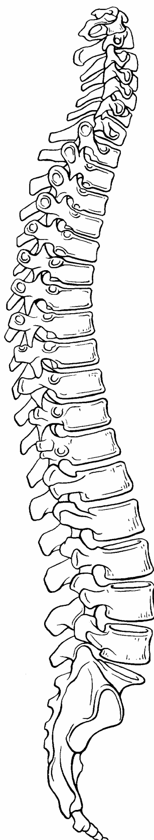
Adult Chiropractic Health Questionnaire

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Our purpose is to care for and educate as many families as possible towards optimal health. Spinal subluxations destroy an optimal spine and your ability to have optimal health. Your experience with this office will not just be of healing but also of learning about optimal health and healing.



Name ______________________ Home Phone ______________________

Address ______________________ Cell Phone ______________________

City, State, Zip ______________________ Work Phone ______________________

Birth date ______________ Age ________ ______________________

Occupation ______________________ Employer ______________________

Marital Status: M Live/with W Sep. D Sin. Spouse/Significant other Name ______________

No. of Children__________ E-mail Address ______________________

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name ______________________

☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? ______________________ ☐ Never

3. When was your last complete spinal examination including x-rays? ________ ☐ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐ YES ☐ NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? ☐ YES ☐ NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.

1. ______________ 2. ______________ 3. ______________

10. What is your motivation to seek/receive care in this office?

____

11. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

____

12. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐ YES ☐ NO Date of Incident ______________________

13. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ☐ YES ☐ NO

14. What activities would you like to do that your health is impairing you from doing?

____

15. How would your life change if you had optimal health? ______________________

____

16. What needs to happen in order for you to have optimal health and healing? __________

____

17. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? ☐ YES ☐ NO

18. Would you like to receive our weekly health and wellness newsletter via e-mail? ☐ YES ☐ NO

HISTORY OF PHYSICAL STRESS Check all that apply and note dates:

BIRTH Were there any problems associated with your mother's pregnancy with you? (Check all that apply)
❑ falls/injury ❑ illness ❑ difficult ❑ other _________
Was your birth: (check all that apply)
❑drug induced ❑C section ❑breech ❑natural ❑forceps/suction
❑prolonged ❑cord around neck ❑home ❑hospital ❑ traumatic
Comments or additional information: ____

GENERAL PHYSICAL TRAUMA: Have you had an accident/near accident, even as a passenger, in a(n): (check all that apply)
❑ automobile ❑ motorcycle ❑bus train ❑bicycle ❑plane ❑other_______________________________
Explain with Dates: ____
Medical interventions: (check all that apply)
❑ hospitalization ❑surgery ❑chemotherapy ❑ casts/collars ❑ traction ❑ braces
❑ shoe lifts etc. ❑physiotherapy ❑ spinal tap ❑ x-ray therapy ❑transfusion ❑ other
❑ organ removal ❑acupuncture ❑ extensive X-rays
Comments: ____
FALLS: ❑from crib ___ ❑tree______ ❑bicycle ___ ❑ steps ____ ❑skates____ ❑ on ice _____
❑ physical fight __________ ❑ armed forces _______ ❑ abuse ______________ ❑ unconscious______
❑used crutch/cane _______ ❑ broken nose ________ ❑ major dental work ______ ❑childhood illness
Please describe daily activities for work, home or school such as sitting, lifting, standing, phone work, sports, exercise, etc.:

____

HISTORY OF CHEMICAL STRESS Please check all that apply:
During your mother's pregnancy did she: (check all that apply):
❑ use prescription drugs ❑use non-prescription drugs ❑chemically induce birth ❑consume alcohol ❑smoke ❑unknown
Comments: ____
Have you and your family members been vaccinated? Y N
Do you or have you ever taken: ❑prescription drugs ❑over the counter drugs ❑antibiotics ❑other
Do you or have you ever worked with: ❑ chemicals ❑ fumes ❑ dust ❑ smoke
Do you consume: ❑ alcohol ❑ coffee/caffeine ❑ tobacco ❑ tap water
❑ recreational drugs ❑ artificial sweeteners ❑ refined sugar ❑ meat ❑ other
Comments: ____

Please describe your eating habits:____

HISTORY OF EMOTIONAL STRESS: Emotional and Mental stress can cause and/or accelerate spinal and nerve dysfunction.
How do you grade your physical health? ❑Excellent ❑Good ❑Fair ❑Poor ❑Getting Better ❑Getting worse
How do you grade your emotional/mental health? ❑Excellent ❑Good ❑Fair ❑Poor ❑Getting Better ❑Getting worse
How do you rate your overall quality of life? ❑Excellent ❑Good ❑Fair ❑Poor ❑Getting Better ❑Getting worse
Please check all that apply and note their severity on a 1-5 scale (1 is the easiest and 5 the most difficult).
❑Childhood ____ ❑ Loss of loved one ____ ❑ Recreation ____ ❑ Family ____ ❑ Work ____
❑Stress of illness ____ ❑ Relationships ____ ❑ Commuting ____ ❑ School ____ ❑ Abuse ____
❑Divorce/separation ___ ❑ Parents divorce ____ ❑ Financial ____ ❑ Lifestyle change ____ ❑ other ______
Comments: ____

Which are you most interested in? ❑Crisis and emergency care ❑ Wellness and maintenance care
Have you ever or do you currently receive the following vehicles toward growth, healing or personal development?
❑ Chiropractic ❑ Somato-respiratory integration ❑ Bodywork ❑ Massage
❑ Osteopathy ❑ Meditation ❑ Psychotherapy ❑ Movement or exercise
❑ Prayer ❑ Rebirthing ❑ Reiki ❑ other _______________
Is there anything else you may wish to share which may help us to better understand you, and why you have chosen to come to this office? ____

____

In Network care people report changes in their physical state, mental emotional states, their body's ability to adapt to stresses, achieve a heightened quality of life and make positive lifestyle choices. Which of these would most excite you to share Network care with your friends and family? ____

The above information is true and accurate to the best of my knowledge.

Signature ____ Today's Date ______________________

Name: ______________________________ **Date:** ____________________

REVIEW OF SYSTEMS- Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less then optimal function.

Check either **I DENY having/had** OR **Circle P for PAST** OR **Circle N for NOW**

CONSTITUTIONAL

❒ **I DENY** having or having had any of the **symptoms or problems listed below.**

- P N chills
- P N daytime drowsiness
- P N fatigue
- P N fever
- P N night sweats
- P N weight gain
- P N weight loss

EYES

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Wear glasses or contact lenses
- P N blindness
- P N Cataracts
- P N Glaucoma

EARS / NOSE / THROAT

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Difficulty/Loss of hearing
- P N Ringing in the ears (tinnitus)
- P N Frequent ear aches
- P N Discharge from the ear
- P N Attacks of vertigo
- P N Sinus trouble
- P N Nasal blockage
- P N Frequent sneezing
- P N Frequent sore throat
- P N Snoring
- P N Recent change in voice quality
- P N Sleep apnea
- P N Difficulty in swallowing
- P N Nose bleeds

RESPIRATORY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Asthma or wheezing
- P N Recent bronchitis or chest cold
- P N Cough
- P N Coughing up blood
- P N Shortness of breath

HEART & CIRCULATION

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Heart attack
- P N High blood pressure
- P N Heart murmur
- P N Chest discomfort (angina)
- P N Heart failure or fluid on the lungs
- P N Palpitations, racing or pounding
- P N Shortness of breath w/activity
- P N Stroke / mini stroke or TIA
- P N Blood clot in artery or vein
- P N "Black out spells"
- P N Aneurysm of any blood vessel
- P N Swelling of legs
- P N Heart surgery
- P N Heart palpitations

STOMACH / INTESTINES

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Ulcer
- P N Frequent heartburn or indigestion
- P N Hiatal hernia and or acid reflux
- P N Poor appetite
- P N Gall bladder attacks
- P N Frequent diarrhea
- P N Chronic constipation
- P N Bright blood bowels or rectum
- P N Abnormal stool
- P N Liver disease or jaundice

ENDOCRINE / METABOLISM

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Thyroid disorder
- P N Unusual hair loss or growth
- P N goiter
- P N Diabetes

KIDNEYS / URINARY TRACT

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Kidney disease or failure
- P N History of kidney dialysis
- P N Kidney stones or infection
- P N Pain or burning with urination
- P N Trouble starting urinary stream
- P N Dribbling or incontinence
- P N Frequent Night Urination
- P N Bladder infections during past year
- P N Blood in urine during past year

MUSCLES / BONES / JOINTS

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Arthritis or other joint disease
- P N Chronic back trouble
- P N Bone or joint surgery in past year

ALLERGY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N anaphylaxis
- P N food intolerance
- P N itching
- P N nasal congestion
- P N rash
- P N sneezing

SKIN

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Rashes, psoriasis or dermatitis
- P N History of skin cancer
- P N New skin growth or mole

NERVOUS SYSTEM

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Headache
- P N Epilepsy or seizures
- P N Date of last seizure:__________
- P N Depression
- P N Other nervous disorder

Specify:____________________

PSYCHOLOGIC

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N anxiety
- P N loss or change in appetite
- P N behavioral change
- P N bi-polar disorder
- P N confusion
- P N convulsions
- P N depression
- P N insomnia
- P N memory loss
- P N mood change

BLOOD

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Bleeding or bruising tendency
- P N Previous blood transfusion
- P N History of hepatitis

MEN ONLY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Testicular swelling
- P N Prostate Problems
- P N Frequent urination

WOMEN ONLY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

- P N Painful periods
- P N Excessive Flow
- P N Irregular cycles
- P N Vaginal Burning
- P N Hot Flash

Are you pregnant? Yes No

Past Medical and Family History

Surgical History: (NONE)______________________________

Hospitalization History: (NONE) ______________________________

Allergy History: (NONE) ______________________________

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes Cancer High Blood Pressure Allergy Hearing Loss Stroke Bleeding Disorder

List any other illness that "runs in your family" (blood relatives): ______________________________

HEIGHT _______ **WEIGHT**_______ **BLOOD PRESSURE** ____________ **PULSE**______ ❑ N/A MINOR

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature:______________________________ Date:____________________

Those in Network Care have reported improvement in the following areas. Please check the areas in which you have an interest in improving. Name____

Improved Physical State relative to:

- ❒ Less physical pain
- ❒ Less tension or stiffness of spine
- ❒ Improved posture
- ❒ Feeling more grounded and connected to body
- ❒ Feeling more flexible
- ❒ Less tension/stress in body
- ❒ Improved, fuller breath
- ❒ More energy
- ❒ Connection to body
- ❒ Trusting body

Improved Mental/Emotional State relative to:

- ❒ Improved positive feelings about self
- ❒ Less moodiness and/or angry outbursts
- ❒ Depression
- ❒ Anxiety
- ❒ Being less reactive to others
- ❒ More interest in life
- ❒ Improved ability to think and concentrate
- ❒ Less anxiety and concern about vague fears
- ❒ Improved ability to stay on task
- ❒ Less distress about pain
- ❒ Connection to self and others
- ❒ Less mind chatter
- ❒ Fears
- ❒ Letting go of past traumas
- ❒ Wider range of emotion
- ❒ Moving out of fight or flight

Improved Response to Stress:
Less stress relative to:

- ❒ Family
- ❒ Significant relationship
- ❒ Health
- ❒ Finances
- ❒ Daily problems
- ❒ Work
- ❒ General well being

Improved Life Enjoyment relative to:

- ❒ Openness to guidance by "inner voice feelings"
- ❒ Experience of relaxation and wellbeing
- ❒ Positive feelings about self
- ❒ Interest in maintaining a healthy lifestyle
- ❒ Feeling open when relating to others

Improved Life Enjoyment relative to:

- ❒ Confidence when dealing with adversity
- ❒ Compassion for and acceptance of others
- ❒ Compassion for self
- ❒ Incidence of feelings of joy or happiness
- ❒ Feeling connected to self
- ❒ Felling connected to others
- ❒ Wellness

Improved Overall Quality of Life relative to:

- ❒ Personal life
- ❒ Extent one adapts to change
- ❒ Handling of problems in life
- ❒ Actual life accomplishments
- ❒ Life as a whole
- ❒ Overall contentment with life
- ❒ Significant other
- ❒ Job Life being what one wants it to be
- ❒ Romantic life
- ❒ Actual work done
- ❒ Co-workers
- ❒ Physical appearance
- ❒ Increase of health promoting practices
- ❒ Decrease of health detracting practices
- ❒ Transformation
- ❒ Spiritual Journey

Please place a star by your top three choices.