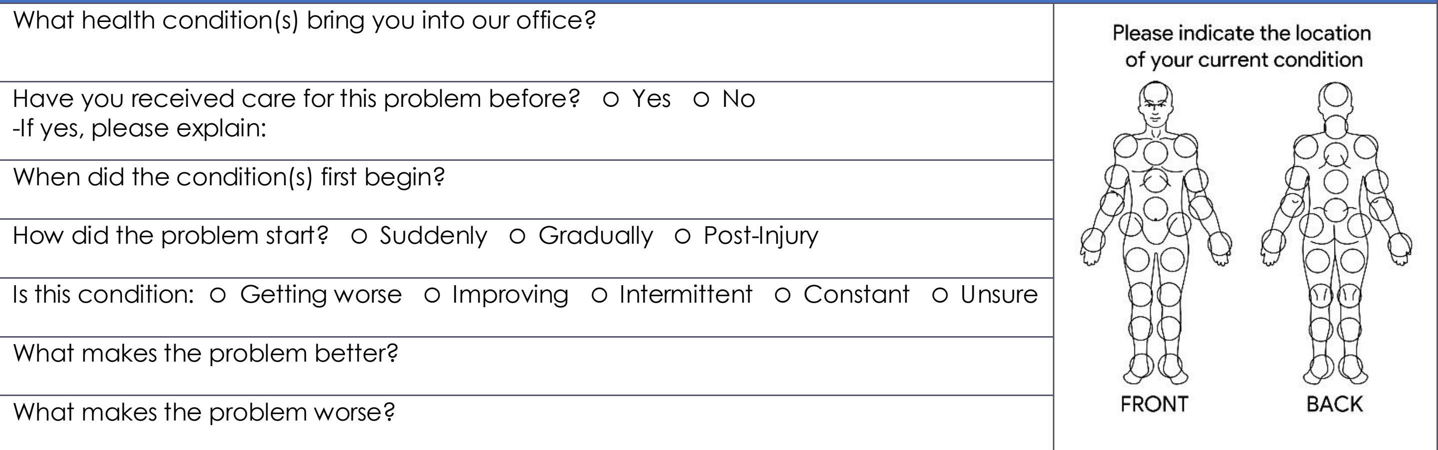
Murdock Family Chiropractic

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS#:	DOB:	Sex:
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Relation:	Emergency Phone:
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? Yes 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?

Have you received care for this problem before? ○ Yes ○ No
-If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

YOUR HELATH GOALS

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?
What is their specialty?
○ Pain relief ○ Physical therapy & rehab ○ Nutrition ○ Subluxation-based ○ Other: ____________

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? ○ Yes ○ No If yes, please explain:

Youth or college sports? ○ Yes ○ No If yes, please list major injuries

Any auto accidents? ○ Yes ○ No If yes, please explain

Exercise Frequency? ○ None ○ 1-2x per week ○ 3-5x per week ○ Daily
What type of exercise?

How do you normally sleep? ○ Back ○ Side ○ Stomach Do you wake up: ○ Refreshed and ready ○ Stiff and tired

Do you commute to work? ○ Yes ○ No If yes, how many minutes per day?

List any problems with flexibility (ex. Putting on shoes/socks etc.)

How many hours per day do you typically spend sitting at a desk or on a computer, tablet or phone?

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		Moderate				None		Moderate		High
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

TOXINS: Chemical & Environment Exposure

Please rate your CONSUMPTION for each:

	None	Moderate			High		None	Moderate			High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs/other that you are taking and why:

ACKNOWLEDGEMENT & CONSENT

Patient Signature: ____ Date: ____________