Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: | Last Name: | Date: / /

SS#: - - | DOB: / / | Sex: M F

Marital Status: | # of Children: | Occupation:

Street Address: | Height: ft. in.

City: | State: Zip: | Weight: lbs.

Email: | Cell Phone: - - | Other Phone: - -

Emergency Contact: | Emergency 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

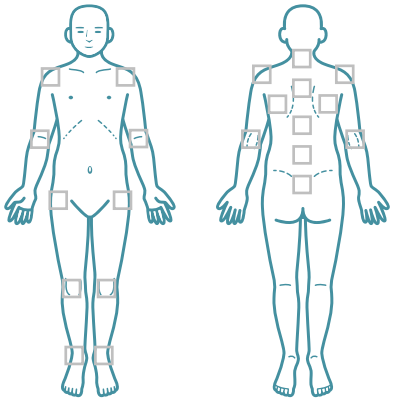
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.



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 HEALTH 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 ◯ Nutritional ◯ 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, 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 types 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 you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental 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.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		Moderate		High		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

ACKNOWLEDGEMENT & CONSENT

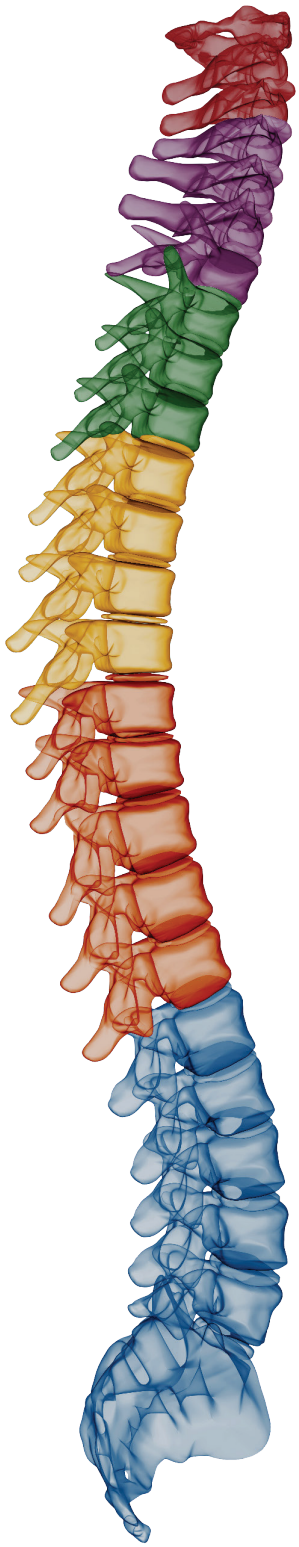
Patient Name: _____ __/__/__

Family First Wellness Center – Dr. Jeffrey S. Haskel & Dr. Kelly Fredricks
1290 Palmetto Ave., Winter Park, FL | 407-647-2220
FFWCFrontdesk@gmail.com | www.FamFirstWell.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	Colic & Excessive Crying	☐	☐
		Ear & Sinus Infections	☐	☐
		Allergies & Congestion	☐	☐
		Immune Deficiency	☐	☐
		Headaches & Migraines	☐	☐
		Vertigo & Dizziness	☐	☐
		Sore Throat & Strep	☐	☐
		Swollen Tonsils & Adenoids	☐	☐
		Vision & Hearing Issues	☐	☐
		Low Energy & Fatigue	☐	☐
		Difficulty Sleeping	☐	☐
		Pain, Numbness & Tingling in Arms to Hands	☐	☐
		Epilepsy & Seizures	☐	☐
		Sensory & Spectrum	☐	☐
		ADD / ADHD	☐	☐
		Focus & Memory Issues	☐	☐
		Anxiety & Stress	☐	☐
		Balance & Coordination	☐	☐
		Speech Issues	☐	☐
		TMJ / Jaw Pain	☐	☐
		Stiff Neck & Shoulders	☐	☐
		Depression	☐	☐
		High Blood Pressure	☐	☐
		Poor Metabolism & Weight Control	☐	☐
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	Reflux / GERD	☐	☐
		Chronic Colds & Cough	☐	☐
		Asthma	☐	☐
		Bronchitis & Pneumonia	☐	☐
		Functional Heart Conditions	☐	☐
Mid Thoracic	• Major Digestive Center • Detox & Immunity	Gallbladder Pain / Issues	☐	☐
		Jaundice	☐	☐
		Fever	☐	☐
		Indigestion & Heartburn	☐	☐
		Stomach Pains & Ulcers	☐	☐
		Blood Sugar Problems	☐	☐
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	Behavior Issues	☐	☐
		Hyperactivity	☐	☐
		Chronic Fatigue	☐	☐
		Chronic Stress	☐	☐
		Allergies & Eczema	☐	☐
		Skin Conditions / Rash	☐	☐
		Kidney Problems	☐	☐
		Gas Pain & Bloating	☐	☐
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	Constipation	☐	☐
		Chrohn's, Colitis & IBS	☐	☐
		Diarrhea	☐	☐
		Bed-wetting	☐	☐
		Bladder & Urination Issues	☐	☐
		Cramps & Menstrual Issues	☐	☐
		Cysts & Endometriosis	☐	☐
		Infertility	☐	☐
		Impotency	☐	☐
		Hemorrhoids	☐	☐
		Sciatica & Radiating Pain	☐	☐
		Lumbopelvic / SI Joint Pain	☐	☐
		Hamstring Tightness	☐	☐
		Disc Degeneration	☐	☐
		Leg Weakness & Cramps	☐	☐
		Poor Circulation & Cold Feet	☐	☐
		Knee, Ankle & Foot Pain	☐	☐
		Weak Ankles & Arches	☐	☐
		Lower Back Pain	☐	☐
		Gluten & Casein Intolerance	☐	☐

Patient Name: _____ Date: ___/___/___

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