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

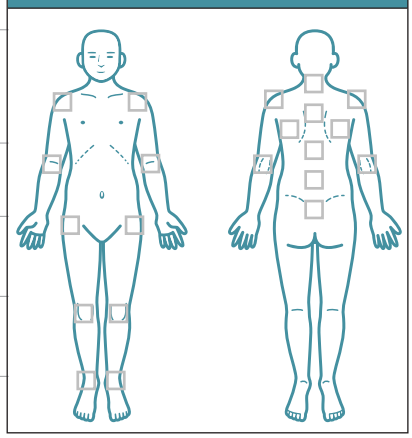
- If yes, please name them and their specialty:

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
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Pregnancy Questionnaire

Patient Name: _____ Date: ___/___/___

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ◯ Yes ◯ No
- If not, please tell us about your previous pregnancy and/or birth experience(s).

Do you plan to follow the same plan as your previous delivery? ◯ Yes ◯ No
- If no, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? ◯ Yes ◯ No
- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? ◯ Yes ◯ No
- If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight? lbs. Current weight? lbs.

Have you experienced morning sickness? ◯ Yes ◯ No
- If yes, please explain:

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions.

Have you taken any medications or supplements during your pregnancy? ◯ Yes ◯ No
- If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? ◯ Yes ◯ No
- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? ◯ Yes ◯ No
- If yes, please explain:

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? ◯ Yes ◯ No

- If yes, please explain:

Are you taking any pre-natal or birthing classes? ◯ Yes ◯ No

- If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? ◯ Yes ◯ No

Who is your birth provider?

Do you intend to have a doula or birth coach present? ◯ Yes ◯ No

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? ◯ Yes ◯ No

- If not, what concerns do you have?

YOUR POST-BIRTH PLAN

Do you plan on breastfeeding your child? ◯ Yes ◯ No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?

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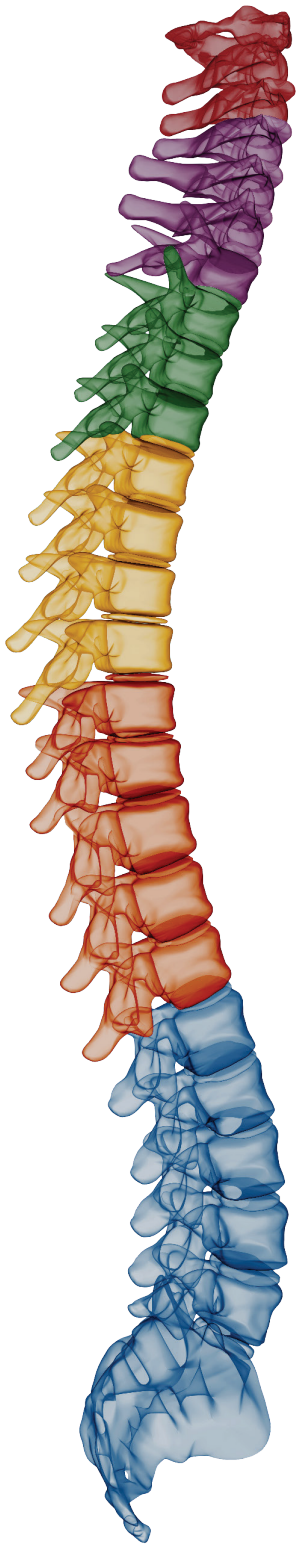
Patient Review of Systems

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)	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: ___/___/___