

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SIN: - -	DOB: / /	Sex: ☐ M ☐ F
Marital Status:	# of Children:	Occupation:
Street Address:	Height: ft. in.	
City:	State:	Postal Code:
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?

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						None				
	Moderate						Moderate				
	High						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						None				
	Moderate						Moderate				
	High						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: _____ Date: ____ / ____ / ____

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

Patient Name: _____

Date: ____ / ____ / ____