Straight Up Chiropractic

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Patient Questionaire

Patient Information

First Name _____ MI _____ Last Name _____

Preferred Name _____ Social Security Number _____

Address _____

City / State / Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Is it okay to contact you at work? ( ) Yes ( ) No

Birthdate _____ Age _____ Sex M F

Occupation _____ Employeer's Name _____

Marital Status S M D W P Other Spouse's Name_____

Number Of Children _____ Children's Name & Ages _____

_____

Who can we thank for referring you or how did you hear about Straight Up Chiropractic? _____

_____

Have you ever had chiropractic care before? □ Yes □ No

If yes, please tell us the doctor's name _____

Were you pleased with your care? □ Yes □ No

Current Health

Most people in our office are here for enhanced development and optimal function for body and mind.

What health condition brings you to our office? _____

_____

When did the symptoms first begin? _____

How did the problem start? ( ) Suddenly ( ) Gradually ( ) Post-Injury

Is this condition ( ) Getting Worse ( ) Improving ( ) Intermittent ( ) Constant ( ) Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Have you ever had a similar condition? ( ) Yes ( ) No

Please explain _____

Have you been treated for this problem before? ( ) Yes ( ) No

Please explain _____

Is this appointment related to an auto accident? ( ) Yes ( ) No

Has you ever been checked for vertebral subluxations? ( ) Yes ( ) No ( ) Don't Know

Health Concerns

( ) Anxiety/Depression
( ) Fatique/Sleep Issues
( ) Digestive Troubles
( ) Dizziness
( ) Nausea/Vomiting
( ) Ringing in Ears
( ) Diabetes
( ) Sensitivity to Light
( ) Hypertension
( ) Loss of Concentration
( ) Arthritis
( ) Memory Problems
( ) Loss of Balance
( ) Headaches
( ) Neck/Back Pain
( ) Stiffness/Flexibility
( ) Pain in Arms/Legs
( ) Sinus Troubles/Allergies
( ) Irritiability
( ) Cold Hands/Feet
( ) Cancer
( ) Other

Explain any boxes checked above or add additional concerns:

_____

_____

Allergies _____

_____

Growth and Development

( ) Anxiety/Depression
( ) Migraine/Headache
( ) Blood Pressure
( ) Cholesterol
( ) Pain Narcotics
( ) ADD/ADHD
( ) Muscle Relaxers
( ) Diabetes
( ) Other _____
( ) Other _____
( ) Other _____

Explain any boxes checked above _____

_____

_____

Emergency Contact

Name _____

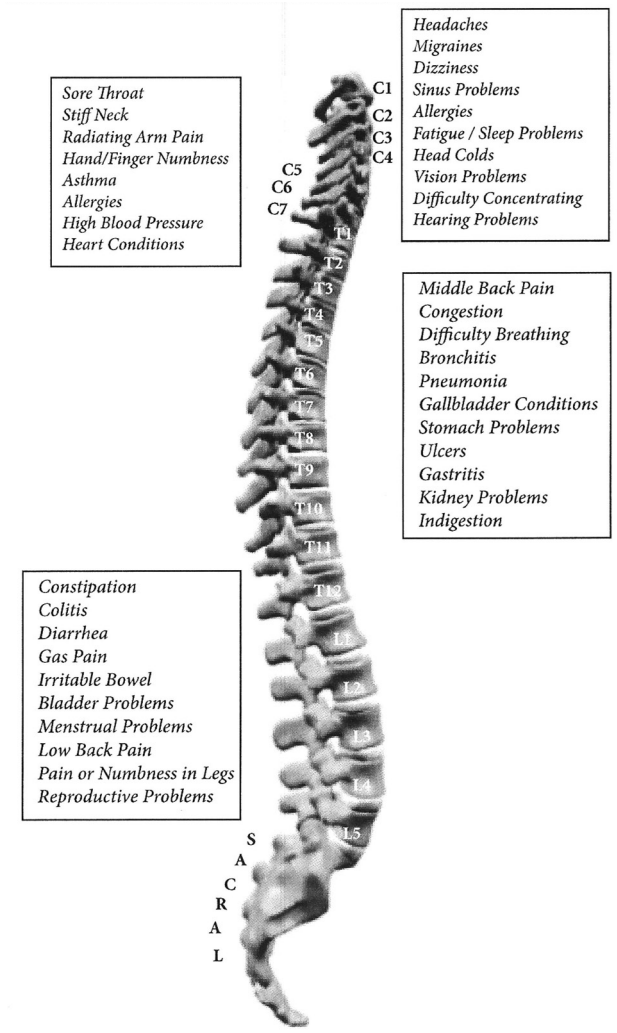
Address _____

City/State/Zip _____

Phone _____

Relation _____

Did you know . . .
Each health condition relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



Vitamins / Supplements

( ) Multi-Vitamin
( ) Fish Oil/Omega 3
( ) Vitamin D3
( ) Probiotics
( ) _____
( ) _____
( ) _____
( ) _____

Explain any boxes checked above _____

_____

_____

_____

Health Status Questionaire

Rate based on a frequency scale of 1 - 5. 1=Never 2=Rarely 3=Occasionally 4= Regularly 5=Constantly

Your Physical Life

Presence of physical pain	1 2 3 4 5	Incidence of colds or flu	1 2 3 4 5
Feeling of tension, stiffness, lack of flexibility	1 2 3 4 5	Ability to work our or engage in activity	1 2 3 4 5
Incidence of fatigue or low energy	1 2 3 4 5	Incidence of chronic disease	1 2 3 4 5

Mental/Emotional State

Presence of negative feelings/energy	1 2 3 4 5	Being overly worried about small things	1 2 3 4 5
Moodiness, temper or angry outbursts	1 2 3 4 5	Difficulty thinking or concentrating	1 2 3 4 5
Difficulty falling or staying asleep	1 2 3 4 5	Feeling of depression or anxiety	1 2 3 4 5

Chemical/Nutritional Life

Eat a well-balanced diet	1 2 3 4 5	Eat an organic, hormone-free diet	1 2 3 4 5
Eat a diet rich in fruit and vegetables	1 2 3 4 5	Use a lot of chemicals on your skin	1 2 3 4 5
Eat fast food or highly processed foods	1 2 3 4 5	Ingestion of chemicals	1 2 3 4 5

Stress Evaluation

Family	1 2 3 4 5	Work/School	1 2 3 4 5
Significant relationship	1 2 3 4 5	Day-to-day stress	1 2 3 4 5
Health	1 2 3 4 5	Finances	1 2 3 4 5

Life Enjoyment

Experienced of relaxation, ease or well-being	1 2 3 4 5	Compassion and acceptance	1 2 3 4 5
Interest in maintaining a healthy lifestyle, diet, etc	1 2 3 4 5	The level of recreation in your life	1 2 3 4 5
Time devoted to things you enjoy	1 2 3 4 5	Your physical appearance	1 2 3 4 5

What else about your health or your life do you feel is important for the doctor to know?

_____

_____

_____

_____

Do you know what subluxation is? ( ) Yes ( ) No

Do any of your friends or relatives see a chiropractor? ( ) Yes ( ) No

If yes, do they use chiropractic for ( ) Health maintenance/optimization ( ) Health problems ( ) Both

Are you seeking chiropractic for ( ) Health maintenance/optimization ( ) Health problems ( ) Both

What would you like to gain from chiropractic care? _____

_____

Pregnancy

Pregnancies _____ # Deliveries _____ # Abortions _____ # Miscarriages _____ # Ectopic Pregnancies _____

First day of most recent period: (LMP) _____ Are your periods regular? ( ) Yes ( ) No

Positive hcg/pregnancy test? ( ) Yes ( ) No

Did you have fertility treatment with this pregnancy? ( ) Yes ( ) No

If you took fertility medications, which one(s) did you take?_____

Method of birth control prior to pregnancy:_____

How long were you on birth control? _____ How long have you been off birth control? _____