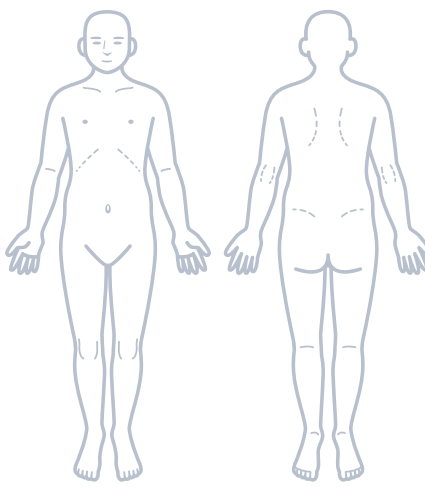


Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
Street Address:	Height:	
City, State, Postal Code:	Weight:	
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 receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> 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?	<p>Please indicate where you are experiencing pain or discomfort.</p> <p>X = Current condition; O = Past condition</p> 
Have you received care for this problem before? <input type="radio"/> Yes <input type="radio"/> No – If yes, please explain:	
When did the condition(s) first begin?	
How did the problem start? <input type="radio"/> Suddenly <input type="radio"/> Gradually <input type="radio"/> Post-Injury	
Is this condition: <input type="radio"/> Getting worse <input type="radio"/> Improving <input type="radio"/> Intermittent <input type="radio"/> Constant <input type="radio"/> Unsure	
What makes the problem better?	
What makes the problem worse?	

Your Health Goals

What are your top three health goals?

- _____
- _____
- _____

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, list major injuries:

Any past auto accidents? Yes No – If yes, please explain:

How often do you exercise? None 1-3x per week 4-6x 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 do you typically spend sitting at a desk? On a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

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

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

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

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

Acknowledgement & Consent

Patient Signature: _____

Date: _____

Cafe of Life Chiropractic

2439 Grand Avenue, Bellmore, NY, 11710 | 100 W Park Avenue, Long Beach, NY, 11561
516-425-0113 | cafeoflifebellmore@hotmail.com | cafeoflife.com

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 not, what would you like to change?

Conception & Early Pregnancy

When is your expected 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?

– Current Weight?

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

What are 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 prenatal 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

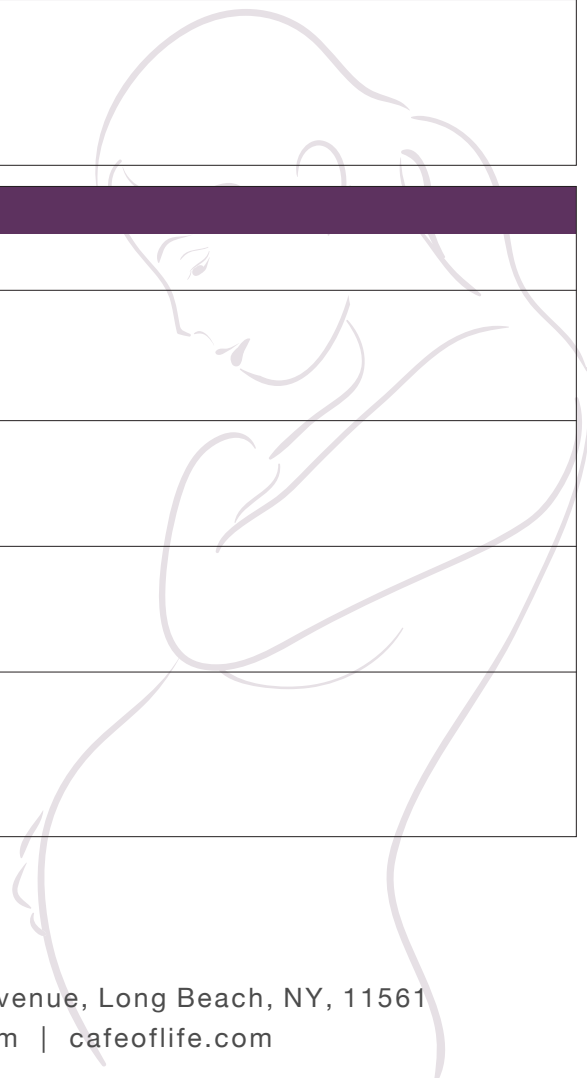
Do you plan on breastfeeding your child? Yes No

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?



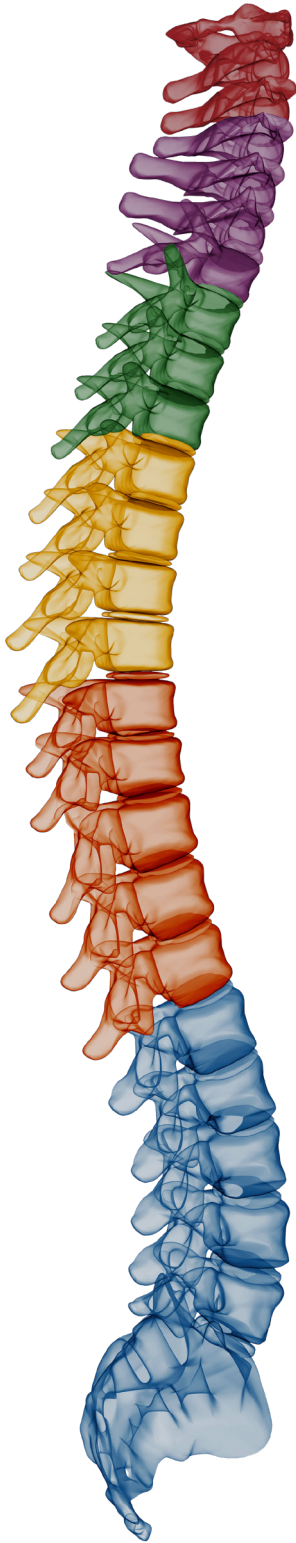
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Patient Review of Systems

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

Patient Name: _____ Date: _____