# RCW Adult New Patient Paperwork

## Adult Patient Questionnaire

### 1. CONFIDENTIAL PATIENT INFORMATION:1

First Name: _____ Last Name: _____ DOB: _____ Gender: ○ M ○ F

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

# of Children: _____

Street Address: _____ Apt./Unit #: _____ Occupation: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Cell Phone: _____ Other Phone: _____

**2.** Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

### 3. How did you hear about us? (please select all that apply & list who in the box that appears)

☐ Current Patient (list who) _____

☐ Professional Referral/Doctor (list who) _____

☐ Google Search _____

☐ Social Media (list platform) _____

☐ Community Partner (list who) _____

☐ Other (specify) _____

**4.** Who is your primary care physician? _____ Date of your last visit: _____

Reason for your last doctor visit: _____

### 5. Are you also receiving care from any other health professionals?

○ Yes ○ No

6. If yes, please name them and their specialty:

| | Name | Specialty |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

7. Please note any significant family medical history:

_____

_____

_____

_____

# CURRENT HEALTH CONDITIONS

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

_____

_____

_____

_____

9. Have you received care for this problem before?

○ Yes ○ No

If yes, which types of care? Please list

_____

10. When did the conditions 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

**11. Your top three goals from care:**

1. _____

2. _____

3. _____

# CHIROPRACTIC HISTORY

**12. What would you like to gain from chiropractic care?**

- ○ Resolve existing challenge
- ○ Overall wellness
- ○ Both

**13. Have you ever visited a chiropractor?**

- ○ Yes
- ○ No

**If yes, which practice(s)?**

_____

**14. What is their specialty?**

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

**If other, specify:**

_____

**15. Do you have any chiropractic concerns for other family members today?**

_____

_____

_____

_____

# TRAUMAS: Physical Injury History

**16. Have you ever had any significant falls, surgeries or other injuries as an adult?**

- ○ Yes
- ○ No

**If yes, please explain:**

_____

17. Notable childhood injuries?

○ Yes ○ No

If yes, please explain:

_____

18. Youth or college sports?

○ Yes ○ No

If yes, list major injuries:

_____

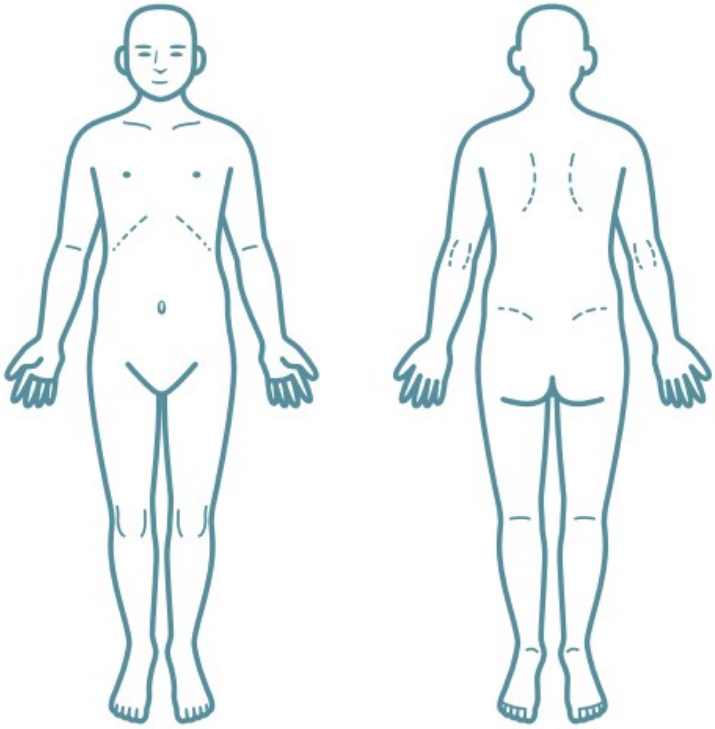
19. Any auto accidents?

○ Yes ○ No

If yes, please explain:

_____

20. *Please indicate where you are experiencing pain or discomfort.*



21. Exercise Frequency?

○ None ○ 1-2x per week ○ 3-5x per week ○ Daily

What types of exercise?

_____

22. How do you normally sleep?

○ Back ○ Side ○ Stomach

Do you wake up:

○ Refreshed and ready ○ Stiff and tired

23. Do you commute to work?

○ Yes ○ No

If yes, how many minutes per day?

_____

24. List any problems with flexibility (ex. Putting on shoes/socks, etc.):

_____

_____

_____

_____

25. How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

_____

## TOXINS: Chemical & Environmental Exposure

26. Please rate your CONSUMPTION for each:

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

27. Are you taking any medications?

○ Yes ○ No

If yes, please list which and why:

_____

28. Are you taking any vitamins or supplements?

○ Yes ○ No

If yes, please list which and why:

_____

## THOUGHTS: Emotional Stresses & Challenges

29. Please rate your STRESS for each:

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

30. Are there other emotional stresses or challenges you'd like to tell us about?

_____

_____

_____

_____

## 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.*

31.

| | Past | Present |
|---|---|---|
| Anxiety & Constant Stress | | |
| Focus & ADHD Challenges | | |
| Difficulty Sleeping | | |
| Low Energy and Fatigue | | |
| Depression and Mood Regulation Challenges | | |
| Lightheadedness & Dizziness | | |
| Vertigo | | |
| Tension Headaches | | |
| Migraines | | |

| | | |
|---|---|---|
| Stiff Neck & Shoulders | | |
| Pain, Numbness, & Tingling in Arms and Hands | | |
| TMJ and Jaw Pain | | |
| Vision & Hearing Issues | | |
| Ear & Sinus Infections | | |
| Sore Throat and Strep | | |
| Strep & Upper Respiratory Infections | | |
| Allergies and Autoimmune Challenges | | |
| Chronic Inflammation | | |
| Acid Reflux, GERD, & Indigestion | | |
| Poor Metabolism & Weight Control | | |
| High Blood Pressure | | |
| Asthma | | |
| Chronic Chest Colds & Cough | | |
| Bronchitis & Pneumonia | | |
| Functional Heart Conditions | | |
| Gallbladder Pain & Issues | | |
| Stomach Ulcers and Pain | | |
| Blood Sugar Problems | | |
| Skin Conditions / Rash | | |
| Ulcerative Colitis | | |
| Crohn's Disease | | |
| IBS | | |
| Kidney Challenges | | |
| Gas Pain & Bloating | | |
| Gluten & Casein Intolerance | | |
| Constipation | | |
| Bladder & Urination Issues | | |
| Cysts & Endometriosis | | |
| Fertility Challenges | | |
| Erectile Dysfunction | | |
| Hemorrhoids | | |
| Low Back Pain & Stiffness | | |

| | | |
|---|---|---|
| Sciatica & Radiating Pain | | |
| Lumbopelvic / SI Joint Pain | | |
| Disc Degeneration | | |
| Leg Weakness & Cramps | | |
| Restless Legs | | |
| Poor Circulation & Cold Feet | | |
| Weak Ankles & Arches | | |

# ACKNOWLEDGEMENT & CONSENT

**32.** Patient Name:

_____

_____ _____

Signature Date