

# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> 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? <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?

Have you received care for this problem before?  Yes  No  
- If yes, please explain:

When did the condition(s) first begin?

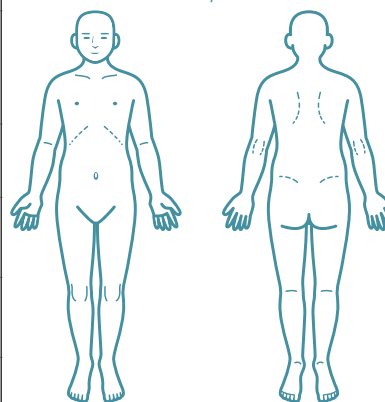
How did the problem start?  Suddenly  Gradually  Post-Injury

Is this condition:  Getting worse  Improving  Intermittent  Constant  Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.  
X=Current condition; O=Past condition



## YOUR HEALTH GOALS

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  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:

	<i>None</i>						<i>High</i>				
	1	2	3	4	5		1	2	3	4	5
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:

	<i>None</i>						<i>High</i>				
	1	2	3	4	5		1	2	3	4	5
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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# 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

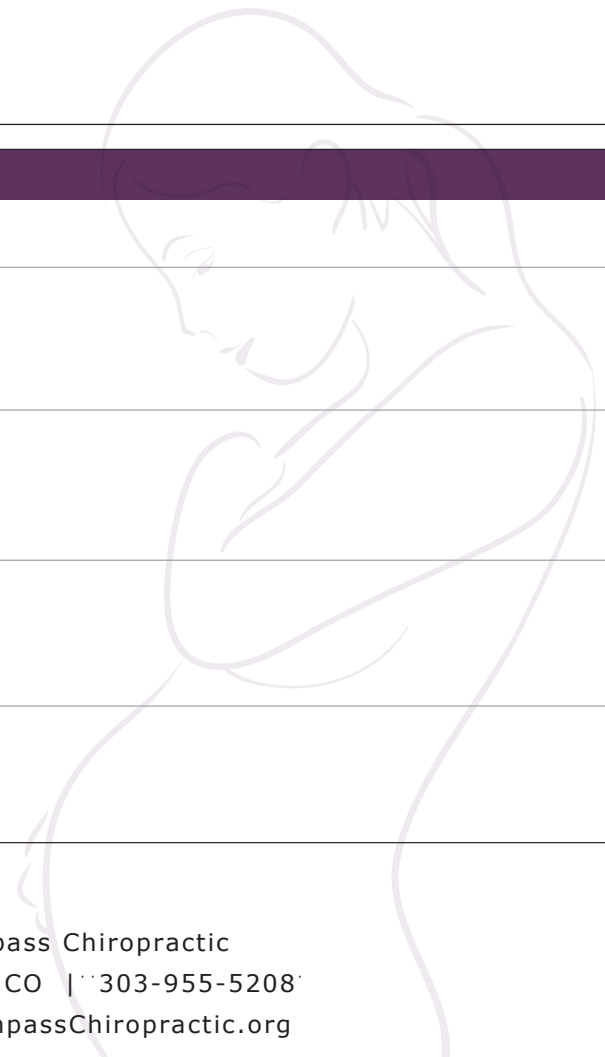
What do you intend to do for vaccines?

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?

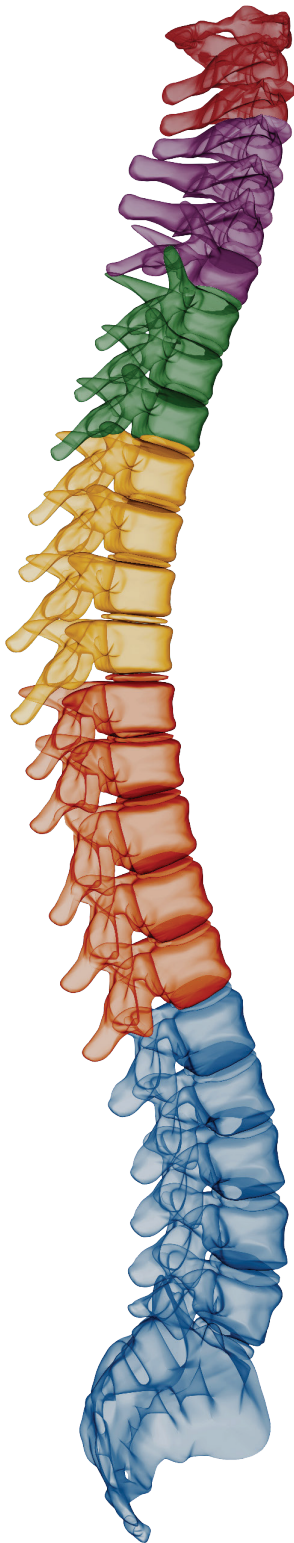
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# Patient Review of Systems

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	PAST	PRESENT			
<b>Cervical</b>	• 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
	<b>Upper Thoracic</b>	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis & Pneumonia
• 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				
<b>Mid Thoracic</b>	• 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	
<b>Lower Thoracic</b>	• 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	
<b>Lumbar, Sacrum &amp; Pelvis</b>	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain	
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness	
	• Major Hormonal Control	<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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_