LIFEForce Chiropractic

Patient questionnaire

To our dear, honored patient,
The following questions pertain to you and your health challenges. Your answers will help us analyze and do our research. To best serve you, we ask that you take the time to answer the questions to the best of your knowledge.

Name:

Address:

City: State: Zip code:

Best number to reach you: Birthdate:

Email address

How many children do you have?

On the following page, please mark the areas on your body that concern/hurt you with a mark or an X:

Dr. Gray's comments:

1. Are you here today for preventative care or do you have symptoms? If you have any symptoms, what are they?

2. How long have you had your problem?

3. Have you had these symptoms in the past? If yes, when?

4. If you have pain, on a scale of 1(weak) -10 (strongest), where are you?

5. Is your pain *constant, increasing or decreasing* (circle one).

6. Do you have pain when you: (circle all that apply)

sneeze/cough / turn your head / take a long walk / stand / most all movements / laying down for longer periods / put on shoes / sit in the car a long time / at night?

7. Do you have pain radiating in your arms or legs?

8. Do you have discomfort / tingling or numbness in your arms or legs?

9. Do you have weakness in your right or left arm or leg?

10. Have you ever been in an accident? What kind of accident? When?

11. Have you ever broken a bone? If so, how and when?

12. Have you ever had surgery? If so, where and why?

13. Are you taking any medicines or dietary supplements? If so, which ones and for what?

14. Have you ever been unconscious? If so, what happened?

15. Do you smoke?

16. Do you ever get dizzy? If so, describe what you're feeling, (spinning, off balance, woozey). How often?

17. Have you seen a doctor for your problem before? Dr.'s name, how often/how long?

18. Was this doctor successful in helping you? For how long?

19. Have you ever seen a psychologist or psychiatrist before? If so, for what reason?

20. Do you have or have you had a lot of sickness in your life? If yes, what was it?

21. If you are a woman, are you pregnant? If yes, is this your first pregnancy? How many months are you pregnant and what is your due date?

22. Do you wear insoles? If so, with or without heel lifts?

23. Have you had a lot of dentistry/orthodontic work done lately? Do you have a lot of gaps along your teeth?

24. Do you wear a mouth guard at night? If so, is it for your upper or lower teeth?

25. Do you grind your teeth?

26. Please give us the name and address of your primary doctor.

27. Do you play sports? If so, which ones and how often?

28. What do you do for a living (motherhood is also a full time job!)?

29. How many hours/day do you sit (ie. in your car, at work, on the sofa)?

30. How many hours/day do you spend on screen time (ie. your cell phone, laptop, Ipad, TV)?

31. Do you sleep through the night or do you wake up a lot during the night? What's your favorite sleeping position?

32. Do you have trouble with your digestive system?

33. Do you have any past X Rays, CT scans, MRI’s?

34. How did you find out about us?

35. What is your expectation of us at our clinic?

36. Are you currently active in a preventative program for your health? What kind of program is it?

Acknowledgment and consent:

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Signature   Date