ADULT FIRST VISIT
(age 16+)

DR. PETER SMITH
CHIROPRACTOR

PERSONAL INFORMATION

Name _____ Date of Birth (MM/DD/YYYY) _____

Email Address _____ ○ Male ○ Female

Address _____ City _____ Province _____ Postal _____

Home Phone _____ Work Phone _____ Cell Phone _____ Best to Contact You at: ○ Home ○ Work ○ Cell

Spouse/Partner's Name _____ Names & Ages of Children Living at Home _____

Occupation/Employer _____ Person Who Referred You to Dr. Smith _____

HOW CAN WE HELP YOU?

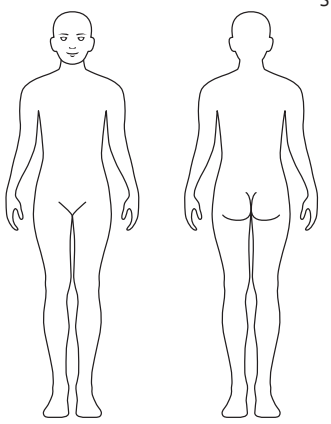
What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms?

0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

Please circle areas where you have pain or other symptoms:



What does it feel like?

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other _____

IMPACT OF YOUR SYMPTOMS

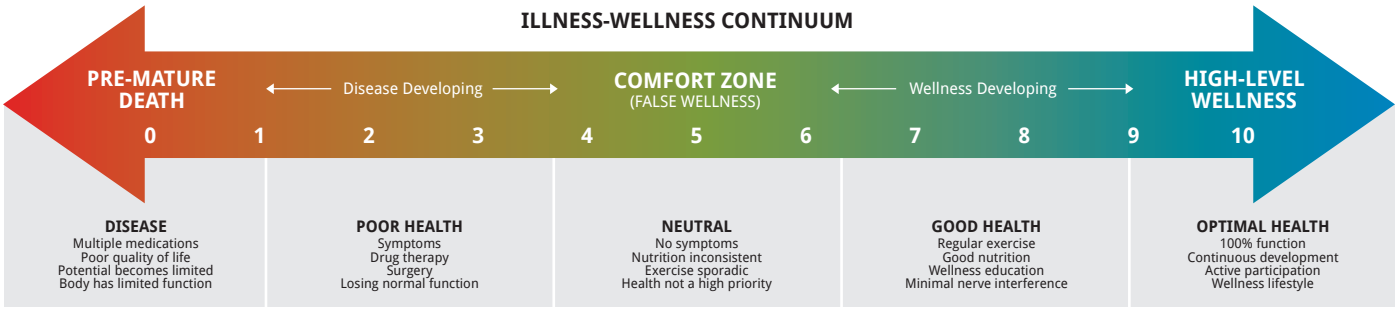
How is this symptom/condition interfering with your life?

	NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT		NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 (NOT COMMITTED) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

HISTORY

What are the most significant accidents/injuries you have suffered?

- ☐ Birth trauma
- ☐ Car accident
- ☐ Slips and falls
- ☐ Sports injury
- ☐ Concussion
- ☐ Fracture
- ☐ Other: _____

What are the most significant postural traumas you have experienced over a prolonged period?

- ☐ Excessive sitting
- ☐ Excessive standing
- ☐ Repetitive lifting
- ☐ Repetitive bending
- ☐ Poor posture
- ☐ Stomach sleeping

List any major surgeries you have had:

_____

_____

What prescription drugs do you take?

_____

_____

HEALTH PROBLEMS:

Please answer everything even if you do not feel it is related to your current problem.

Y N Neck pain
Y N Pain in arms/hands
Y N Hearing problems
Y N Weakness in grip
Y N Dizziness
Y N Visual problems
Y N Coldness in hands
Y N Jaw pain/clicking
Y N Numbness/tingling in arms
Y N Headaches/migraines
Y N Thyroid conditions
Y N Sinus problems
Y N Allergies/hay fever
Y N Frequent colds/flu
Y N Low energy/fatigue

Y N High blood pressure
Y N Irregular heartbeat
Y N Shortness of breath
Y N Asthma/wheezing
Y N Heart attack/angina
Y N Heart palpitations or murmurs

Y N Painful deep breathing
Y N Lung infections or bronchitis

Y N Pain in ribs/chest
Y N Nausea
Y N Gastric reflux
Y N Pain between shoulder blades
Y N Indigestion/heartburn
Y N Hypoglycemia/diabetes
Y N Fatigue/irritability after eating, or if you haven't eaten for a while

Y N Low back pain
Y N Pain in hips/legs/feet
Y N Muscle cramps in legs/feet
Y N Coldness in legs/feet
Y N Numbness in legs/feet
Y N Weakness in hips/legs/feet
Y N Menstrual problems
Y N Sexual dysfunction
Y N Constipation/diarrhea
Y N Recurrent bladder infections
Y N Urinating frequently or with difficulty

TERMS OF SERVICE

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. (Please note that all fees are due at the time service is rendered. We do not bill patients or insurance companies.)

PREGNANCY RELEASE (females under age 55)

○ I AM pregnant (initials: _____)

○ I AM NOT pregnant (initials: _____)

The START of my last period was: _____

_____ SIGNATURE

_____ DATE