Jackson Family Chiropractic
Adult Chiropractic Health Questionnaire

Name _____**Best Phone Number to Reach You** _____

Mailing Address _____**City/State/Zip** _____

Birthdate _____ **Age** _____ **Height** _____**Weight**_____

Email Address _____

Occupation _____ **Employer** _____ **Referred by** _____

Status: (Circle) MARRIED WIDOWED SEPARATED DIVORCED SINGLE **Spouse Name** _____

Please answer the following questions:

* **What is your complaint (the biggest health concern)?** _____ When did it begin? _____

****One complaint per section, please!**

How did this problem begin? _____

Have you had this condition in the past? YES NO Is your condition: BETTER WORSE NOT CHANGING

Which side is your complaint on? LEFT RIGHT BILATERAL CENTRAL

Please rate your pain on a scale of 1 to 10 (0=no pain and 10= excruciating pain): **1 2 3 4 5 6 7 8 9 10**

How intense is your complaint? NO EFFECT MINIMUM MILD MODERATE SEVERE UNBEARABLE

Describe the nature of your symptoms: BURNING DULLACHE NUMB SHARP SHOOTING TIGHTNESS
TINGLING THROBBING RADIATES TO: _____

How often do you experience your symptoms? CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day)
OCCASSIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

What makes your symptom better? ACUPUNCTURE CHIROPRACTIC HEAT ICE MASSAGE THERAPY
NOTHING WORKS PAIN MEDS PHYSICAL THERAPY REST STRETCHING

What activities aggravate your condition? _____

*** What is your second biggest health concern?** _____ When did it begin? _____

How did this problem begin? _____

Have you had this condition in the past? YES NO Is your condition: BETTER WORSE NOT CHANGING

Which side is your complaint on? LEFT RIGHT BILATERAL CENTRAL

Please rate your pain on a scale of 1 to 10 (0=no pain and 10= excruciating pain): **1 2 3 4 5 6 7 8 9 10**

How intense is your complaint? NO EFFECT MINIMUM MILD MODERATE SEVERE UNBEARABLE

Describe the nature of your symptoms: BURNING DULLACHE NUMB SHARP SHOOTING TIGHTNESS
TINGLING THROBBING RADIATES TO: _____

How often do you experience your symptoms? CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day)
OCCASSIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

What makes your symptom better? ACUPUNCTURE CHIROPRACTIC HEAT ICE MASSAGE THERAPY
NOTHING WORKS PAIN MEDS PHYSICAL THERAPY REST STRETCHING

What activities aggravate your condition? _____

Turn Page Over To Finish Application

*** What is your third biggest health concern?** _____ When did it begin? _____

How did this problem begin? _____

Have you had this condition in the past? YES NO Is your condition: BETTER WORSE NOT CHANGING

Which side is your complaint on? LEFT RIGHT BILATERAL CENTRAL

Please rate your pain on a scale of 1 to 10 (0=no pain and 10= excruciating pain): **1 2 3 4 5 6 7 8 9 10**

How intense is your complaint? NO EFFECT MINIMUM MILD MODERATE SEVERE UNBEARABLE

Describe the nature of your symptoms: BURNING DULLACHE NUMB SHARP SHOOTING TIGHTNESS
TINGLING THROBBING RADIATES TO: _____

How often do you experience your symptoms? CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day)
OCCASSIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

What makes your symptom better? ACUPUNCTURE CHIROPRACTIC HEAT ICE MASSAGE THERAPY
NOTHING WORKS PAIN MEDS PHYSICAL THERAPY REST STRETCHING

What activities aggravate your condition? _____

**Do you have more complaints? YES NO. Please describe: _____

Please answer the following questions:

Auto and work injuries can cause serious problems. Is this visit related to an auto or work injury? YES NO

Have you ever been told that you have a spinal curvature, spinal arthritis or inherited spinal problem? YES NO

Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? YES NO

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to twist, stretch or crack your neck, mid or lower spine? YES NO

Is your health keeping you from enjoying your favorite hobbies or activities? If so, what? _____

Stress can cause or aggravate spinal problems. Please rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

Are you currently taking prescription medication? YES NO If so, how many? _____

Spinal health is especially important during pregnancy. If female, is there any chance that you are pregnant? YES NO MAYBE

Have you ever been diagnosed with cancer? YES NO If so, what kind? _____ Year diagnosed _____

Have you ever had spinal surgery? YES NO If yes, where? _____

If Dr. Jackson feels that you will benefit from chiropractic care are you willing to follow his recommendations? YES NO

How will you be paying for today's visit? CREDIT/DEBIT CASH CHECK OTHER_____

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the office.

Signature _____ **Date** _____