**Jackson Family Chiropractic**
**Adult Chiropractic Health Questionnaire**

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

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

**Birthdate** _____**Male or Female (Circle) Age** _____ **Height** _____**Weight**_____

**Email Address** _____

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

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

## * What is your worst complaint (Please circle one and answer the questions based on this complaint only)?

**Neck Pain** **Mid-Back Pain** **Low Back Pain** **Other Complaint** _____

How and when 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 complaint (Please circle one and answer the questions based on this complaint only)?

**Neck Pain** **Mid-Back Pain** **Low Back Pain** **Other Complaint** _____

How and when 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? _____ _____
**Initials**

Turn Page Over to Finish Application and Sign.

## * What is your third complaint (Please circle one and answer the questions based on this complaint only)?

**Neck Pain** **Mid-Back Pain** **Low Back Pain** **Other Complaint** _____

How and when 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

Have you ever had a chiropractic adjustment? YES NO If so, when was your last chiropractic? _____

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_____

Who should we call in case of an emergency? _____ Relationship? _____ Phone #: _____

**The above information is true and accurate to the best of my knowledge.**

**Signature** _____ **Date** _____