Chiropractic Questionnaire

Welcome to the Riordan Clinic!

Name: _____ Date: _____

Who may we thank for referring you? _____

Have you ever had chiropractic care before? _____ If yes, how long ago? _____

Health reasons for consulting our office (please indicate onset of condition):

1. _____
2. _____
3. _____
4. _____

Have you ever had same or similar problem(s) before? _____ Yes _____ No

How long? Please explain:

_____

_____

Do any movements, positions, activities, make the problem(s) better or worse?

_____

_____

Please indicate the type of pain you are having: □ Sharp □ Dull □Throbbing □ Numbness □ Aching □ Shooting □ Burning □Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

Please describe, if applicable, any ways in which the problem interferes with your daily activities?

_____

_____

Father/Mother/Brother/Sister/Children with similar problems?

_____

What treatment have you received for your condition? □ Medication(s) □ Surgery □ Physical Therapy □ Acupuncture □ Massage □ Chiropractic Services □ Other _____

_____

What do you attribute your problem to? _____

If left unattended for another 5 years, how do you think this problem would affect you?

_____

Please rate on a scale of 0 to 10 what this problem is when it is at its **worst**?

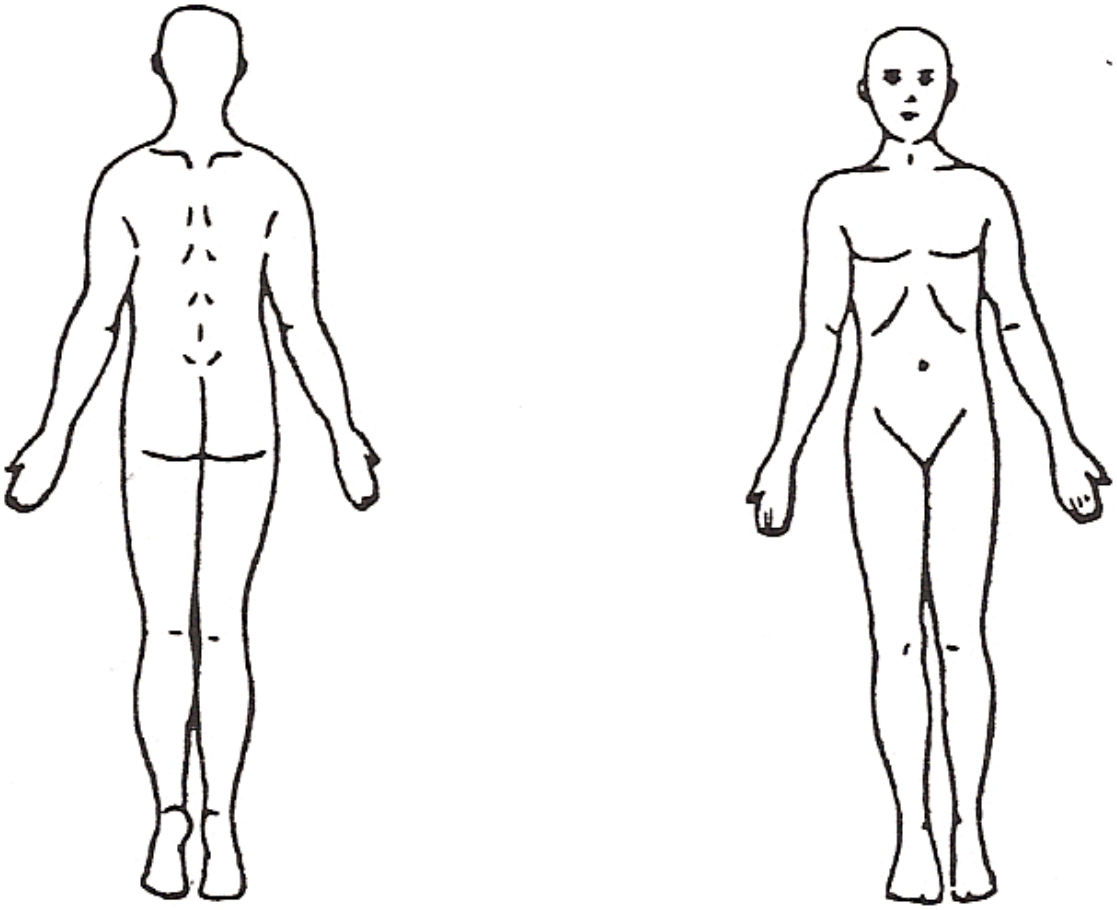
0 1 2 3 4 5 6 7 8 9 10

Please rate, on a scale of 0 to 10, what this problem is when it is at its **best**?
0 1 2 3 4 5 6 7 8 9 10

Please rate on a scale of 0 to 10 what this problem is **right now**?
0 1 2 3 4 5 6 7 8 9 10

Is this the result of an auto or work injury? _____ Yes _____ No If so, when? _____

Please circle location of pain:



The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

_____ _____
Patient or Guardian's Signature Date

_____
Patient or Guardian's Name