GROSMAN CHIROPRACTIC

3625 E. Thousand Oaks Blvd., Bldg. C #168
Westlake Village, CA 91362
(805) 558-0286

NEW PATIENT QUESTIONAIRRE

Today's Date: _____

Demographics

Name:_____ Date of Birth:_____-_____-_____ Age:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Mobile Phone:_____
Work Phone:_____ Email:_____
Gender:_____
Occupation:_____ Employer:_____
Whom may we thank for referring you to this office?:_____

Chiropractic Experience

Have you ever been to a chiropractor? Yes No Date of Care:_____to_____
Reason for Care:_____
What were the results?:_____

History of Condition(s) and/or Concern(s)

Please identify the condition(s)/concern(s) that brought you to the office in order of importance:
First:_____ Second:_____
Third:_____ Fourth:_____
On a scale of 1 to 10 with 10 being the worst pain, rate your above condition(s)/concern(s) by circling
First: 1 2 3 4 5 6 7 8 9 10 Second: 1 2 3 4 5 6 7 8 9 10
Third: 1 2 3 4 5 6 7 8 9 10 Fourth: 1 2 3 4 5 6 7 8 9 10
When did the condition(s)/concern(s) begin?:_____
The condition(s)/concern(s) is due to: Injury Repetitive Use Weakness/Lack of Use Emotional Stress Unknown
The quality of the condition(s)/concern(s): Radiating Burning Dull/Aching Numb/Tingling Sharp/Stabbing
How often are you aware of the condition(s)/concern(s)?:
Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Intermittent (0-25%)
What time of day is the condition(s)/concern(s)at its worst? Morning Midday Evening
The condition(s)/concern(s) has been: Getting Better Getting Worse Staying the Same
What makes the condition(s)/concern(s) FEEL BETTER?:_____
What makes the condition(s)/concern(s) FEEL WORSE?:_____
Who have you consulted for the condition(s)/concern(s)?:_____
Have you ever had similar condition(s)/concern(s)? Yes No
When? (if applicable):_____

General Health & Lifestyle

Have you stopped doing any activities since the onset of the condition(s)/concern(s)? Yes No
Please list (if applicable):_____

Please circle any of the following conditions that YOU have experienced:

Difficulty Concentrating	Skin Condition	Allergies
Heart Condition	Fainting Spells	Sinus Condition
Food Sensitivity	Menstrual Issues	Thyroid Condition
Recent Infection/Fever	Arthritis	HIV/AIDS
Respiratory Condition	Seizure	Attention Issues
Digestive Condition	PMS	Depression
Jaw Pain	Diabetes	Anxiety
Difficulty Breathing	Prolonged Fatigue	Addiction Issues
Stroke	Prostate Condition	Heartburn
Headaches	Cancer	Vision Issues
Kidney Condition	Fibromyalgia	Muscle/Joint pain other
Weight Gain/Loss	Asthma	than Sports Injury
Dizziness	Ringing of Ears	High Cholesterol
Bladder Condition	Blood Pressure Issues	

WOMEN ONLY:Are you currently pregnant? Yes No

Family History

Please circle any of the following conditions that a FAMILY member has experienced:

Diabetes Stroke Cancer Arthritis Obesity Anxiety

Depression Blood Pressure Issues High Cholesterol

Patient Signature: _____ Date:_____