Tennessee Chiropractic Alliance

Health & Wellness Questionnaire

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Date: _____ **Preferred Name if Different:** _____

Check the boxes for any of the following symptoms that you may have experienced:

☐ Headaches/Migraines	☐ Dizziness	☐ Tired/Fatigue
☐ Neck Pain	☐ Low Back Pain	☐ Fibromyalgia
☐ Elbow, Wrist or Hand Pain	☐ Hip or Knee Pain	☐ Digestive Problems
☐ Numbness/Tingling in Arms or Hands	☐ Ankle or Foot Pain	☐ Ringing in the Ears
☐ Shoulder Pain	☐ Numbness/Tingling in Legs or Feet	☐ Nervousness
☐ Tension Across the Shoulders	☐ Muscle Weakness	☐ Difficulty Sleeping
☐ Pain Between Shoulder Blades	☐ Loss of Balance	☐ Other _____
☐ Sinus/Allergy Problems	☐ Plantar Fasciitis	

Patient Information

Language:	**Race**:	**Ethnicity:**
☐ English	☐ White	☐ Hispanic or Latino
☐ Spanish	☐ American Indian or Alaska Native	☐ Not Hispanic or Latino
☐ Indian	☐ Asian	☐ Decline to Answer
☐ Japanese	☐ Native Hawaiian or Other Pacific Islander	
☐ Chinese	☐ Black or African American	
☐ Korean	☐ Hispanic or Latino	
☐ French	☐ Decline to Answer	
☐ German	☐ Other: _____	
☐ Russian		
☐ Other: _____		

Our office uses text messaging to send appointment reminders and occasional direct patient communication. We never send text blasts or group messages. Do we have your permission to send you text messages?

☐ Yes, you may send me text messages. Please use the following number: **Cell Phone #:**_____ **Cell Carrier:**_____	☐ No, you may not send text messages. I prefer to get my appointment reminders and other communication via: _____ Phone call: Home # _____ Phone call: Work # _____ Phone call: Cell # _____ Email