Today's Date_____

Consultation

Name:_____ Date of Birth_____
Chief Complaint:_____

1. When did it start?(date)_____
2. Did it begin suddenly or gradually?_____
3. Did anything cause the onset? Yes No
   If so what?_____
4. Have you ever had anything like this before? Yes No
5. Can you point to the exact location to the pain? Yes No
   If so mark the area on the charts to the right
6. Does it radiate to another part of your body? Yes No
   If so where?_____
7. Do you have symptoms in any other part of your body? Yes No
8. Describe the sensation (dull, sharp, burning, aching, gnawing,
   Shooting, constricting, other)_____
9. Describe the intensity (mild, moderate, severe) _____
10. Has your condition: improved____ same____ worse____
11. Have you found anything that makes it better? Yes No
    (rest, morning, night, certain positions)_____
12. Does anything seem to make it worse? Yes No
    (morning, night, coughing activities) _____
13. Has there been any change in your bodily functions? Yes No
    (urination, respiration, digestion, bowel, vision)_____
14. Has your condition affected daily activities? Yes No
    if so in what way? _____
15. Have you tried any store bought or home remedies? Yes No
16. Have you sought any other professional care for this? Yes No
17. Do you have any other symptoms or problems? Yes No
    if so what?_____

Patient Introduction

Today's Date_____Date of Birth_____

Name_____

Street Address_____City_____

State_____ Zip Code_____ Home Phone_____ Cell Phone_____

Employer Name_____ Business Phone_____

Employer Address_____

Occupation_____

Spouse's Employer_____Occupation_____

Marital Status: Single___ Married___ Separated___ Widowed___ Divorced___

Entrance Complaint_____ When did this condition begin?_____

Did any type of injury or accident occur? If so describe when, where and how _____

_____

Were you treated else where?_____

Have you had any recent xrays?_____When was your last visit to a Chiropractor?_____

Have you ever sustained a severe injury?(ie. Auto accident, major falls, ect)_____

_____

List any of the following and dates of each:

Operations_____ Fractures or Dislocations:_____

Medications?_____ Glasses?_____Contacts?_____ Dentures?_____

Habits: Cups per day of: Coffee_____Tea_____Milk_____Water_____
Intake per day of: Alcohol_____ Tobacco_____

How much exercise to you get daily/weekly other than work?_____

Do you have insurance?_____ Name of Company_____

Policy Numbers: Member_____Group_____

Below please Check anything that bothers you Currently, and Circle anything that has bothered you in the past

General Symptoms
Allergies
Chills
Fatigue
Fever
Loss of Sleep
Nervousness
Neuralgia
Numbness or pain in arms hands or legs
Sweats
Weakness
Weight Gain
Weight Loss
Wheezing

Skin
Boils
Bruises easily
Hives or allergies
Itching
Sensitive skin
Varicose veins

Head
Convulsions
Dizziness
Fainting
Headache

Eyes
Double vision
Eye pain
Eye strain
Failing vision

Ears
Deafness
Earache
Ear noises

Nose
Colds
Nosebleeds
Postnasal drip
Sinusitis
Sneezing

Throat
Difficult swallowing
Enlarged glands
Hay fever
Hoarseness
Throat
Nasal drainage
Red throat
Sore throat
Sinus infection
Tonsillitis

Respiratory
Asthma
Chest pain
Chronic cough
Difficult breathing
Spitting up blood
Spitting up phlegm

Cardiovascular
Hardening of the arteries
High blood pressure
Low blood pressure
Pain over heart
Previous heart attack
Poor circulation
Rapid beating heart
Slow beating heart
Swelling of ankles

Musculoskeletal
Backache
Faulty posture
Joint pain
Pain between shoulders
Spinal curvature
Stiff neck

Gastrointestinal
Belching or gas
Colitis
Colon trouble
Constipation
Diarrhea
Difficult digestion
Distention of abdomen
Excessive hunger
Gall bladder trouble
Heartburn
Hemorrhoids
Hernia
Liver trouble
Nausea
Poor appetite
Vomiting
Vomiting of blood

Genitourinary
Bed-wetting
Blood in urine
Discharge
Frequent urination
Inability to control urine
Kidney infection or stones
Painful urination
Prostate trouble
Pus in urine sores

Female-Reproductive
Congested breast
Cramps or backache
Excessive flow
Hot flashes
Irregular cycle
Lumps in breast
Menopausal symptoms
Painful menstrual periods
Previous miscarriage
Vaginal discharge
Are you pregnant? Yes no

Past History
Appendicitis
Arthritis
Asthma
Bone disease
Cancer
Chicken pox
Diabetes
Diphtheria
Eczema
Gonorrhea
Influenza
Malaria
Measles
Mental illness
Mumps
Pleurisy
Pneumonia
Polio
Rheumatic fever
Scarlet fever
Small pox
Tonsillitis
Tuberculosis
Typhoid fever
Venereal infection
Whooping cough

Family History
Allergies
Arthritis
Cancer
Diabetes
Heart disease
Hemophilia
Kidney disease
Tuberculosis
Other_____

Please use this space to list anything else you feel we might need to know_____
_____
_____