

# Consultation History

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Do you have any concerns about seeing a Chiropractor? \_\_\_\_\_

Please Check All Health Concerns:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Pain/Tension/Numbness
<input type="checkbox"/> Migraines	<input type="checkbox"/> Allergies	<input type="checkbox"/> neck <input type="checkbox"/> shoulders
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Asthma	<input type="checkbox"/> legs <input type="checkbox"/> low back
<input type="checkbox"/> Weight trouble	<input type="checkbox"/> Bladder trouble	<input type="checkbox"/> arms <input type="checkbox"/> hands
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Digestive troubles
<input type="checkbox"/> Irritability	<input type="checkbox"/> Nervousness	<input type="checkbox"/> constipation <input type="checkbox"/> gas
<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> diarrhea <input type="checkbox"/> bloating

Which one of these conditions prompted your visit today? \_\_\_\_\_

Which one of these conditions affects your life the most? \_\_\_\_\_

When was the first time in your life you felt the condition that prompted your visit today and how many episodes have you had in the past 5 years? \_\_\_\_\_

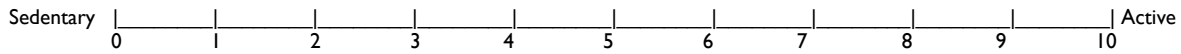
**Has there been any trauma or accidents in your lifetime whether you think it directly affected this condition or not.**

Injury & Surgical History	Description	Date
Sports played		
Falls		
Head injuries		
Broken Bones		
Dislocations		
Auto accidents		
Work accidents		
Surgeries		

**Since the first episode of this problem what, if anything, have you tried in an effort to feel better?**

Previous Care History	Date	Results and Comments
Primary Care		
Specialist		
Physical Therapy		
Pain Medication		
Ice or Heat		
Rest		
Surgeries		
Hoped it would go away		

**What is your current level of activity?**

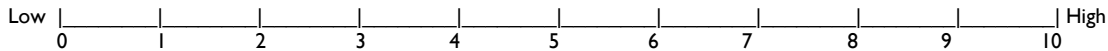


I work at a desk most of the day?  yes  No How many years? \_\_\_\_\_

I exercise at the gym \_\_\_\_\_ days per week.

I exercise outside or in organized sports \_\_\_\_\_ days per week.

**My level of stress is?**



Reason \_\_\_\_\_

**How does this condition affect your attitude?** (Apathy, grief, anger, moody, irritable, exhausted, tired) \_\_\_\_\_

**When your problem is at its worst how does it affect work?** (Decision making, decreased productivity, exhausted at the end of the day, unable to work long hours etc.) \_\_\_\_\_

Does it make it harder to do your job? \_\_\_\_\_

Are you getting less done? \_\_\_\_\_

Do you have to take more breaks? \_\_\_\_\_

Has your boss said anything about it yet? \_\_\_\_\_

**When your problem is at its worse how does it affect your family?** \_\_\_\_\_

Is there anything that your condition is keeping you from doing with your family or at home? \_\_\_\_\_

Who's more disappointed you or them? \_\_\_\_\_

How do they react to your pain? Do they know and understand you are not feeling well? \_\_\_\_\_

**Have you given up any hobbies or interests because of this problem?**

Describe \_\_\_\_\_

**Has this problem interrupted your sleep pattern yet?**

Yes  No

Trouble falling asleep due to being uncomfortable?

Yes  No

Not enough restful sleep?

Yes  No

Awakening in the middle of the night?

Yes  No

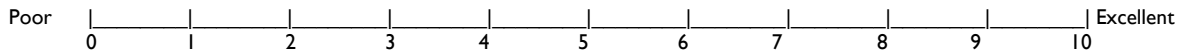
Waking earlier than you normally would?

Yes  No

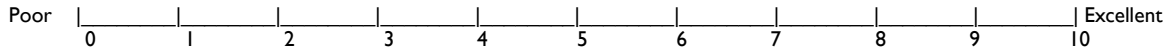
When was the last time you regularly had a good night sleep? \_\_\_\_\_

When the problem is at its worst, how much older does it make you feel? \_\_\_\_\_

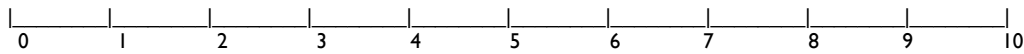
**How would you rate your general health?**



**Where would you expect to rate your health in 5 years if you don't change anything?**



**On a scale of 0-10, ten being the highest, rate your commitment to getting rid of this problem.**



Is there anything preventing you from getting this problem taken care of?

Concerns: Time, Transportation, other. Specify: \_\_\_\_\_  
\_\_\_\_\_

**Goals:**

What would be the first thing you want to change? \_\_\_\_\_  
\_\_\_\_\_

List any activities that you would like to be able to do again and who would you be doing this activity with?  
\_\_\_\_\_  
\_\_\_\_\_

How does this problem prevent you from doing that? \_\_\_\_\_  
\_\_\_\_\_

What are your expectations of treatment? How long do you expect it to take before you are doing well?  
\_\_\_\_\_  
\_\_\_\_\_