

CONSULTATION HISTORY

Patient's Name: _____ Date: _____

Major Complaint: _____

What have you heard about chiropractic? _____

Does anyone else in the family have this same problem or a similar one? Yes No

Who? _____

Have you had this problem longer than a week or two? Yes No If yes, how long? _____

Have you had this problem more than 2 or 3 times? Yes No

If yes, how often? _____

Before you began to suffer with this problem, was there an earlier accident, injury or condition that could have brought this about or be related to it? (Example: fall, auto injury, work injury, sports trauma, repetitive motion on the job) Yes No _____

What have you tried to do to get rid of the problem that did not work? _____

Have you become worried about getting this problem handled? _____

Describe how it feels when this problem is at its worst? _____

Compare a day with this problem at its worst to a day without the problem ...

How does it effect/interfere with your work? _____

How does it effect/interfere with your family life? _____

How does it effect/interfere with your hobbies? _____

How does it effect/interfere with your social life? _____

When it is at its worst, how much older does this problem make you feel? _____

What could make this problem worse? _____

On a scale of 1-10, ten being the highest, rate your commitment to getting rid of this problem. _____

Do you have children? Yes No

Names _____ Ages _____

Do they have earaches, allergies, colds, headaches, other problems? _____