Initial Consultation / Current Health Condition

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Patient : ____________________________ Chart # ________________ Date ___ / ___ / ___.

What are your symptoms today?____ which ***side?*** Right / left / both / center
(Why are you here / What hurts)

When did this start? ______________________________ Since then, are symptoms getting ____better ____worse ____ same

How did this start? ________________________________ Where does it ***radiate?*** __________________________________

Has this happened ***before***? Yes / No Explain: ____

How ***frequent*** is the pain? ___ often ___ occasional ___ constant How ***severe*** is the pain? 1 2 3 4 5 6 7 8 9 10

What makes it ***better?*** ______________________________ What makes it ***worse?*** __________________________________

Describe your pain : stiff sore burning dull aching sharp shooting numb tingling stabbing gnawing tight tender
(circle ***all*** that apply)
Other : Please ***explain*** ____

When is your pain at it's ***Worst*** : early AM late AM afternoon evening night ***Explain*** : ______________________________
(circle all that apply)

When is your pain at it's ***Best*** : early AM late AM afternoon evening night ***Explain*** : ______________________________
(circle all that apply)

What makes the pain ***worse***: lay sit stand walk turn bend forward / backwards ***Other*** : ______________________________
(circle all that apply)

What makes the pain ***better***: lay sit stand walk turn bend forward / backwards ***Other*** : ______________________________
(circle all that apply)

What ***job or play*** activities hurt***?*** ____________________________ Describe your ***stress level***? ☐ low ☐ medium ☐ high ☐ very high

MD's seen for this condition : __________________________ ***Results*** : ____

CHIROPRACTORS seen before: __________________________ ***Results*** : ____

Do you or have you ever had : ***A Stroke Cancer Diabetes Heart Disease Lung Disease other:*** _________________________
(circle all that apply)
Explain : ____

List All Surgeries : Head Brain Heart Lung Neck Back Shoulder Arm Hand Hip Leg Foot ***Other:*** ______________________
(circle all that apply)
Results : ____

In the ***Past Year*** have you…Been in the ***Hospital***? Yes / No ***Explain*** : ____

In the ***Past Year*** have you…Had any ***Major Infections***? Yes / No ***Explain*** : ______________________________________

Do you get ***Dizzy / Pass out*** / have history of ***Strokes***? Yes / No ***Explain*** : ______________________________________

What ***Major Traumas*** have you suffered in you lifetime? ______________________________ ________________________
(include ***any and all*** accidents, falls and injuries)
______________________ ______________________ ______________________

List ***All Medications & Illnesses*** : ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________

List any ***other health problems*** you have : ____

Doctor's Notes : ____
____ ***rev. 01/09/06***