REIMER CHIROPRACTIC HEALTH CENTER

Initial Consultation Form

Patient's Name:______________________ Date:____________________

Primary Complaints:____
____
____

Please describe your condition when it is at its worst:_______________
____
____

Please circle the appropriate rsponses:

Overall frequency of Complaint: (circle one please)
Constant - 100% of the time Frequent - 75% Intermittant - 50% Occasional - 25%

Overall intensity of Complaint: (circle one please)
Minimal (An annoyance but has no effect on activity)
Slight (Tolerable with some impairment to activity)
Moderate (Tolerable with marked impairment of activity)
Severe (Intolerable and cannot perform any activities)

Is your problem affecting any other area of your body? If yes, explain:_______________
____
____

Does it interfere with your normal daily activities (Work, family, recreation)?_________
How?____
____

What aggravates the problem?____
____

What relieves the problem? (What have you tried for relief)?____________________
____

If this went without being taken care of, how do you think it would affect you?________
____

Any questions or
concerns?____
____

_________________________________ _________________________
Patient's Signature Date