CONSULTATION/HISTORY FORM

Patient_____ Date ____/____/____ Birthdate ____/____/____ Sex: M F
Address_____ APT#_____ City _____ State ____ Zip Code _____
Telephone _____ Cell _____ SSN# ____-____-____ Driver's Lic. # _____
Occupation _____ Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip Code _____
Spouse Name _____ Spouse Employer _____ City _____ State _____
EMAIL ADDRESS _____ Person/Emergency_____ ( ) -
Send appointment reminders via: __Email __Text How far in advance: __1 Day __4 Hours __2 Hours
Cell Phone Carrier_____

In order to conduct a thorough consultation, you must complete each question below:

Is this ☐Work-Related ☐Auto Related ☐Not Applicable Date of last Physical ____/____/____

(Females) Are you pregnant? Y N If yes, how many months ____ # of Births ____ Are you on Birth Control? Y N
Date of last period____/____/____

Chief Complaint_____When and How did it start?_____

_____

How often is your symptom present? (Occasional) ☐1-25% ☐26-50% ☐51-75% ☐76-100% (Constant)

What is the intensity of your complaint: (No Pain) __0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10 (Unbearable)

This past week, how much does the pain interfere with daily activities (work, social activities, household chores)?

(No interference) ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 (Unable to carry on any activities)

Have you ever had a previous episode, if so, when?_____

Any other doctors seen for this condition? Y( ) N( ) Dr's. Name_____ When_____

Treatment received? ☐ Meds _____ ☐ Surgery _____

☐ P.T. _____ ☐ Other_____

What else have you tried?_____

Any secondary complaint?_____

Surgeries/Hospitalizations (what/when)?_____

_____

Previous chiropractic care (who/when)? _____

Family history (serious illness/ age deceased)?_____

_____

Diet?_____Exercise?_____ Recreation_____

Check all that apply to you: ☐Recent Infection ☐Recent Fever ☐HIV/AIDS ☐Diabetes ☐Corticosteroid Use ☐High Blood Pressure☐Stroke (date)_____ ☐Dizziness/Fainting ☐Numbness groin/Buttocks ☐Urinary Retention ☐Frequent Urination ☐Aortic Aneurysm ☐Cancer/Tumor ☐Osteoporosis ☐Recent Trauma ☐Prostate Problems ☐Abnormal Weight Gain ☐Abnormal Weight Loss ☐Epilepsy/Seizures ☐Visual Disturbances ☐Arthritis ☐History of Alcohol Use ☐History of Tobacco use

[*OFFICE: Hx taken by & reviewed with patient.* Doctor's Signature_____] I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes to my health condition or health plan coverage in the future.

Patient Signature _____ Date _____/_____/_____

TREATMENT OPTIONS

We provide treatment in our office for 2 basic categories of health problems:

1. Simple health condition – This is a health problem that is acute (just started, that is non-traumatic, and for which the patient has never experienced before. It typically involves only one symptom or area.
2. Complex health condition – This is a health problem that is chronic (has been going on for longer than just a week or two), one that has been recurring over a time, or one that involves more than just one symptom or area.

Some patients have no idea what to expect as far as the treatment they will require when they present for care. The following treatment options will help you understand, and decide which type of care is best for you:

Please check the type of care desired so that we may help you achieve your health goals.

_____ Symptom Relief Care – This type of care is recommended for simple health condition category above.

_____Stabilization Care – This type of care is recommended for the complex health condition category.

_____Check here if you want the doctor to select the type of care that is appropriate for you condition.