



CONSULTATION

Name: _____ Date: _____ Referred by: _____

MAJOR COMPLAINTS/SYMPTOMS:

Pain Scale: (1-10):

Location of pain:

Frequency and Duration of pain:

When first noticed:

Has this condition previously occurred in the past:

What/When triggers your symptoms (ex: morning, walking, exercising, sleeping etc):

What relieves your symptoms:

Any radiating pain/shooting pain into extremity? Where?

What have you done for this condition on your own? Did it help?

Have you seen other doctors for this condition? (if yes who)

Medication recommended and/or taking for this condition?

Surgery recommended/ History of previous surgeries related to your current condition:

Review of systems: Circle any that apply and/or add any additional (eg: heart, liver, lung, ENT, GI, diabetes, cancer, dizziness, weight loss, trauma, pacemaker/hardware)

Previous x-ray/MRI/CT for your current condition: (when/where?)

Previous Chiropractic Tx: (when/where?)