

INITIAL CONSULTATION FORM

Patient's Name: _____ Date: _____

Beside Optimizing Your Health, What Other Reasons Do You Have For Seeing The Chiropractor? : _____

What Changes The Symptoms? (Makes The Symptoms Better/Worse.) _____

Have You Had Any Changes In Your Energy Levels, Mental Focus, Or Disposition? _____

Have You Noticed Any Other Changes In Your Body? (Difficulty Breathing, Visual Changes, Changes In Urination Or Bowel Habits, Etc...) _____

Have You Ever Had Any Falls, Traumas, Car Accidents, Fractures, Or Surgeries? _____

Please circle the appropriate response:

Overall Frequency of Complaint: (circle one please)

Constant-100% of the time Frequent-75% Intermittent-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)

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

Any questions or concerns? _____

INITIAL CONSULTATION FORM

CHIROPRACTORS NOTES

Patient's Name _____

Reason for Seeking Your Health: What Other Reasons Do You Have for Seeking The

Chiropractor? _____

What Changes The Symptoms? (Please The Symptoms Better/Worse) _____

Have You Had Any Changes In Your Energy Levels, Mental Focus, Or Digestion? _____

Have You Noticed Any Other Changes In Your Body? (Difficulty Breathing, Vision Changes, _____

Changes In Urination Or Bowel Habits, Etc.) _____

Have You Ever Had Any Falls, Trauma, Car Accidents, Fractures, Or Surgery? _____

Please circle the appropriate response:

Overall Frequency of Complaint (circle one please) _____

Constant (100% of the time) Frequent (75% of the time) Intermittent (50% of the time) Occasional (25% of the time) Rare (10% of the time) Never

Overall Intensity of Complaint (circle one please) _____

Severe (Annoying but not affecting activity) _____

Moderate (Interfering with some important activity) _____

Mild (Interfering with normal important activity) _____

Not at all (Inconspicuous and causes no activity restriction) _____

If this were without being taken care of, how do you think it would affect you? _____

Any questions or concerns? _____