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?_____

CHIROPRACTORS NOTES