Health First Chiropractic Clinic, P.C.

Consultation History

Patient Name: ____ **Today's Date:** ___________________

If applicable please circle one: **Auto Accident** **Work related injury** **Other (please specify)** __________

Major Complaints:

A) ____ **D)** ____
B) ____ **E)** ____
C) ____ **F)** ____

What have you heard about Chiropractic? ____

Which of your major complaints bother you the most? (circle one) **A** **B** **C** **D** **E** **F**

How long have you had the complaint(s)? ____

Prior to the problem beginning, did you ever have an earlier problem that was the same or similar? _________
____

Did it appear (circle one) **Slowly** **Immediately**

Does anyone else in your family have this problem or a similar one? ____________________________________
____

How often does it bother you now? ____

When it is at its worst, how does it feel? ____

When it is at its worst, how does it interfere with your normal daily activities? ___________________________
____

Does this problem reduce your productivity or effectiveness regarding your work? _______________________

What have you done to aggravate the problem? ____
____

How much older than you are, does your current problem make you feel? ________________________________

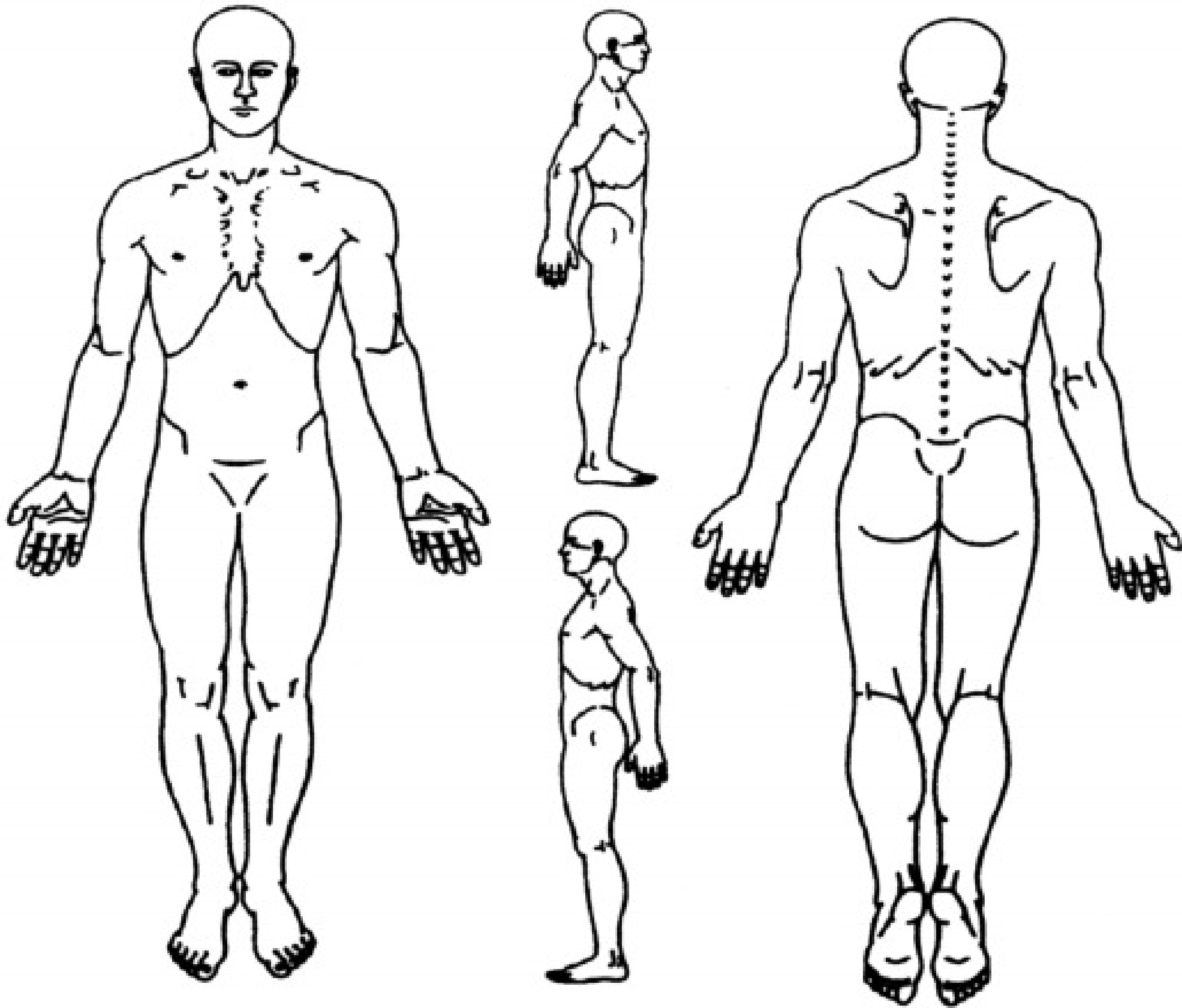
If your problem was left unhandled for five years, how do you think it would affect you? __________________
____

Are you committed to getting rid of not only your symptom(s) but what has caused it, even if it requires a change in your lifestyle? (circle one) **yes** **no**

Do you have children? If so please tell me about them, names and ages? Are they healthy, do you have any health related concerns for them? ____
____
____

On the diagram below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

Pain = P   Tingling = T   Numbness = N   Burning = B   Stiffness = S



Circle the severity of your pain on the scale of 0 – 10.

Extreme Pain										**No Pain**
10	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**

Please write any additional information you would like the Doctor to be aware of: ________

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Patient Name: ______________________________________ **Date:** __________________