



Adult Consultation History

Date _____

Your Name: _____ Gender M F

Your Main Complaint: _____

Any other Complaints: _____

How long have you suffered with this problem? _ _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

How much older does this make you feel: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___ Intermittent ___ Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

Are you on any type of medication? _____ Please list all: _____

Could your problem have been caused by an injury at work? _____

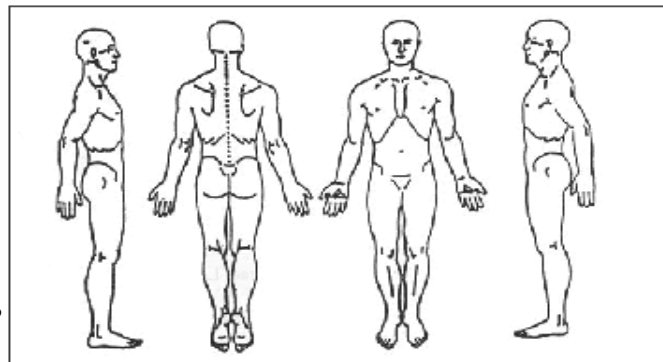
If yes, please give us the details: _____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this? _____

Using the adjacent body charts, please circle ALL affected areas. →



Have you ever been treated by a medical physician for this pain? Yes _____ No _____ If so, where? _____

Have you had any previous surgeries? _____

Have you ever had any fractures or broken bones? Yes _____ No _____ Where\When: _____

Are you taking any of the following medications? Nerve Pills _____ Pain killers (including aspirin) _____

High Blood Pressure Medication _____ Cholesterol Medication _____ Anxiety Medication _____

Muscle Relaxants _____ Blood Thinners _____ Tranquilizers _____ Insulin _____

Other(s): _____

Please mark the following conditions you may have had or have now:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> HIV (AIDS)	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Is there anything else you would like the Doctor to know?

For Women Only

Date of your last menstrual period: _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____

Are you pregnant? _____ If so, how far along? _____

SIGNATURE: _____ DATE: _____

Thank You!