CONSULTATION HISTORY

Name: _____ Date: _____

Major Complaint:
_____
_____

Onset
When did it happen? _____
What caused it?_____
Gradual or sudden?_____

Chronology/Timing
Is the problem constant or intermittent? _____
Does it prevent sleep?_____
Is it worse in the morning or night?_____
It is getting worse/better/staying the same?_____ _____
Has this ever happened before?_____

Quality
Describe the pain/symptoms:
_____
_____

Severity
Is the pain mild/moderate/severe?_____
Pain Scale 1-10 10 being worst pain:_____
Does the pain affect work/hobbies/getting dressed?:_____

Modifying Factors
What increases the symptoms or pain?_____
What makes it better?_____

Associated Symptoms
Do you have any other symptoms or problems that you feel are related to this complaint?_____
_____
Do you have any numbness/tingling/weakness into extremities?_____
Does your back catch or lock?_____
Any changes in bowel/bladder habits?_____

Previous Treatment
Have you ever seen a chiropractor before?_____
If so, What is the name?_____
What was the diagnosis?_____

Past Health History
Illnesses/hospitilizations/surgeries?_____
_____
_____

General Trauma, Accidents, Injuries?_____
_____
_____

Diet/Habits/Exercise
How would you describe you diet?_____
Do you follow a regular exercise program?_____
Do you smoke/have you ever smoked?_____

Medications
Do you take any prescription medications? If so list:_____
_____
_____
Do you take over the counter medications? If so list:_____
_____
_____

X-Rays
Have you ever had x rays?_____
Where there any problems identified?_____

Family Health Problems
Family History of: Cancer/Diabetes/High blood pressure/stroke/heart problems/high cholesterol?_____
_____
Any other family health concerns_____

**What is one thing we can set as a goal to work toward that you have wanted to do since this condition developed that you haven't been able to do?