



Adult Consultation History

Your Name: _____

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? _____

Do you have any children? _____

Do they have any health problems that you are aware of? _____

Is there any other information you would like us to know? _____

I attest that all the information provided on this form is true to the best of my knowledge.

SIGNATURE: _____ DATE: _____

I give permission for patient info and photos to be used anonymously for Research purposes.

SIGNATURE: _____ DATE: _____

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? _____

Thank You!