



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: _____

On a scale of 1 to 10, with 10 being the highest, rate your level of pain: _____

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? _____

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!

Below is a list of problems which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST 6 MONTHS OR FOR A SIGNIFICANT AMOUNT OF TIME IN YOUR LIFE:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain between Shoulders
- Neck Pain
- Shoulder Pain R or L
- Knee Pain R or L
- Hip Pain R or L
- TMJ problems/Clicking Jaw
- Sports Injuries

NERVOUS SYSTEM CODE

- Numbness
- Confusion
- Dizziness
- Forgetful/Memory Problems
- Speech delay
- Depression/Anxiety
- Fainting
- Parkinson's
- Cold/Tingling Extremities
- Stress
- ADD/ADHD
- Autism
- Behaviour Issues
- Dyslexia
- Learning difficulties
- OCD
- PDD
- Premature aging
- Fever
- Aspergers
- Learning disability
- Epilepsy/Seizures

GENERAL CODE

- Fatigue
- Allergies
- Trouble Sleeping/Insomnia
- Headaches/Migraines
- Gas/Bloating After Meals
- Irritable Bowel Syndrome
- Colitis
- Acid Reflux/Heartburn
- Fibromyalgia

ORTHOTIC CODE

- Foot/Heel Pain R or L
- Plantar Fasciitis
- Bunions
- Shin Splints
- Flat Feet

C-V-R CODE

- Chest Pain
- History of Stroke
- Shortness of Breath
- Asthma
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

EENT CODE

- Vision Problems
- Dental Problems
- Stuffed Nose/Sinus Problems
- Sore Throat
- Ear Aches/Ringing in Ears
- Hearing Difficulty

DO YOU HAVE A REGULAR EXERCISE PROGRAM?

Yes No
Describe: _____

LIFESTYLE STRESS LEVEL

- High
- Moderate
- Very Little

FEMALES ONLY

When was your last period? _____
Are you pregnant?
 Yes No Not Sure

GASTRO-INTESTINAL CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discoloured Urine
- Abdominal Cramps
- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble

MALE/FEMALE CODE

- Prostate/Sexual Dysfunction
- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps

ANYTHING ELSE??

PLEASE READ CAREFULLY:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all service rendered me are charged directly to me and I am personally responsible for payment.

PATIENT'S SIGNATURE X _____ DATE _____

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments:

Thank you!