CONSULTATION QUESTIONNAIRE

Name____ Date_______________________

Age______________ Birth date______________ Height______________ Weight______________

Referring Doctor____________________________ Family Doctor_____________________________

What is your reason for this visit?____

____

Past Medical History: (Please check conditions you have or have had)

_____High Blood Pressure
_____Heart Attack/Disease
_____Congestive Heart Failure
_____Head Injury/Trauma
_____Irregular Heart Beat
_____Arrhythmias
_____Heart Valve Problems
_____Mitral Valve Prolapse
_____Pacemaker
_____Automatic Defibrillator
_____Shortness of Breath
_____Asthma/Wheezing
_____Emphysema
_____Headaches
_____Pneumonia
_____Chronic Cough
_____Sleeping Problems
_____Joint Pain/Swelling

_____Tuberculosis
_____Stroke/TIA
_____Chest Pain
_____Multiple Sclerosis
_____Polio
_____Epilepsy/Seizures
_____Vision Problems
_____Glaucoma
_____Anemia
_____Leukemia
_____Sickle-Cell Anemia
_____Major Burns
_____Hernia
_____Weight Loss/Gain
_____Hepatitis
_____HIV/AIDS
_____Ulcers
_____Arthritis

_____Drug/Alcohol Dependency
_____Liver/Kidney Disease
_____Recent Cold/Bronchitis
_____Diabetes
_____Thyroid Disease
_____Cancer
_____Heartburn/GI Problems
_____Pulmonary Embolism
_____Respiratory Problems
_____Bowel/Bladder Problems
_____Bleeding Disorder
_____Blood Clots/Circulation Problems
_____Depression/Anxiety/Stress
_____Sexually Transmitted Disease
_____Currently/Possibly Pregnant
_____Numbness/Weakness
_____Aches/Pains
_____Other (Please List)

____

Is there any family history of the above conditions? If yes, please explain:_________________________

____

____

Medications: (List current medications and doses)

Medication/Food Allergies

Hospitalizations: (Serious illnesses, injuries, surgeries)

<u>Date</u> <u>Hospital</u> <u>Problem</u>

____

____

____

____

Social History:

Are you: _____Married _____Single _____Widowed _____Divorced
Do you smoke? Yes / No How much?____
Do you drink alcohol? Yes / No How much?____
What is your occupation?____
What are your hobbies?____
Have you been able to continue working?____
Have you been able to function at home with usual activities?____________________________________

Review of Symptoms: (Please check any current, recent or ongoing symptoms)

_____Easy Bruising/Bleeding _____Night Sweats _____Fever/Chills
_____Fatigue _____Weight Loss _____Sleep Difficulties
_____Abdominal Pain _____Rectal Bleeding _____Abnormal Vaginal Bleeding
_____Blood in Urine _____Other____

Treatment for Problem:

Since your problem began, which of the following treatments have you had? Please fill in types, dates and amount of relief (none, mild, moderate, excellent).

Date		Relief
__________	Medications____	______________
__________	Surgeries____	______________
__________	Traction____	______________
__________	Physical Therapy____	______________
__________	Chiropractic/Osteopathic Manipulation _______________________	______________
__________	Nerve Block____	______________
__________	TENS Unit____	______________
__________	Biofeedback/Relaxation Training_____________________________	______________
__________	Counseling/Psychotherapy_________________________________	______________
__________	Massage Therapy____	______________
__________	Acupuncture____	______________
__________	Other____	______________

What testing have you had for your problem?

Date	Test	Results
__________	CT	____
__________	MRI	____
__________	X-Rays	____
__________	EMG	____
__________	Bone Scan	____
__________	Lab Work	____

Since your problem began, what other physicians or chiropractors have you seen?

Date	Name
__________	____
__________	____
__________	____
__________	____

Do you have PAIN? YES / NO ***If YES, please complete the following.**
***If NO, please skip to the end for signature.**

Where is your pain?____
When did it start?____
Was your pain related to a specific injury? Yes / No If yes, please describe your injury:
____
____

On the drawing at the right, shade the areas where you feel pain, "X" the areas that hurt worst:

Please circle your pain level on the scale:

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

Least Pain Ever
0 1 2 3 4 5 6 7 8 9 10

Worst Pain Ever
0 1 2 3 4 5 6 7 8 9 10

Circle the word/words that describe your pain:

Sharp Dull Aching Burning Tingling

Throbbing Shooting Constant Intermittent

How long can you: SIT______________________
STAND______________________
WALK______________________

What makes the pain: BETTER?_____________________________________
WORSE?_____________________________________
Does it hurt to bend?____
Does it hurt to lie down?_______________________________________
How much can you comfortably lift?______________________________
Do you have any numbness? Yes / No If so, where?_________________
Do you have any tingling? Yes / No If so, where?_________________
Do you have any weakness? Yes / No If so, where?_________________
Do you have any loss of control of bowel/bladder function?__________
Does your pain INCREASE with: Coughing? Yes / No
Sneezing? Yes / No
Bowel Movements? Yes / No
Do you have any muscle twitching or spasms? Yes / No If yes, where?______________
____
____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor responsible for any errors or commissions that I have made in the completion of this form.

_________________________________ _________________________

Patient Signature **Date**