CONSULTATION FORM

NAME_____ **DATE**_____

How did this injury happen?

Onset? ACUTE GRADUAL CHRONIC

Root cause of symptoms?

Prior Pain? Cervical Thoracic Lumbar Left Right Bilateral

Have symptoms changed? Improving Getting Worse No Change

Rate of change? Gradually Slowly Slightly

Changed since? Last Visit Treatment Began Last Month Last Week This AM

PAIN

Quality ? Achy Burning Dull Sharp Stiff Throbbing

Description? Mild Moderate Severe

Level 0 1 2 3 4 5 6 7 8 9 10

How often does pain occur? Constant Frequent Intermittent Occassional

Frequency? 0 1 2 3 4 5 6 7 8 9 10

Time parameter? Hour Day Week Month

Radiating pain to any other areas? _____

During what part of the day does pain feel worse? _____

What exacerbates symptoms? (standing,lifting, movement etc…) _____

Any time the symptoms improve or feel better? _____

What alleviates symptoms? _____

Any Numbness? _____

Any Spasms? _____

Any Weakness? _____

Any Swelling? _____

Disability Indice(s) score? _____

Have you seen a Medical Doctor for this condition before? YES NO
If yes, When & Where

What was the diagnosis?

Were you shown X-rays? YES NO

What was the result of your care there? (circle one)
Pain is worse Pain is the same Pain is a little less Pain is gone

Did the Doctor recommend any surgery or drugs?

Have you seen a Chiropractor for this condition? YES NO

What were the results from your care there?

What remedies have your tried yourself? How did the remedies help?

Have you ever had: Surgeries Fractures Car Accidents Falls
Work Injuries Serious Illnesses

Comments: _____

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