Adult Consultation History

PATIENT NAME: _____ DATE: _____

Welcome!

Your Name: _____ Today's Date: _____

Address: _____City:_____

_

State:_____ Zip:_____

S.S.#: _____ Date of Birth: _____ Health insurance? _____

Which is/are the best phone(s) to reach you? Cel Phone: _____

Home Phone: _____ Work Phone: _____

Email: _____@_____._____

How did you hear about our practice?: _____

Complaints / Wellness Goals: _____

_____

How long have you suffered with this/these problem(s)?: _____

What do you think caused it?: _____

What treatments have you tried that DIDN'T work?: _____

_____

Have you ever seen a Doctor of Chiropractic before?: _____

If so, what was your experience?: _____

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: _____

Personal life: _____

Are you married with a spouse or partner? _____ If so, spouse's name: _____

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Do you have any children at home with you? Names and ages:

_____

_____

_____

_____

Do your children or spouse/partner have any health problems that you are aware of?: _____

_____

_____

For Women Only:
Date of your last menstrual period: _____
Do you use any means of contraception? _____
Do you experience severe cramping with your menstrual period? _____Headaches ?: _____
Do you suffer from PMS? _____

Is there anything else you would like me to know?: _____

_____

_____

_____

The above information is true to the best of my knowledge:

SIGNATURE: _____ DATE: _____

Thank You!

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