ADULT CONSULTATION HISTORY

Your name: _____

Your main complaint: _____

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 &\or the fact that it continues to persist & recur? : _____

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?

Family: _____

Work: _____

Hobbies: _____

Everyday Life: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment level in helping us solve this problem: _____

What gives you some temporary relief? : _____

What is the pattern of this problem? Constant Intermittent Occasional Cyclic

What effect does it have on your body functions? _____

_____

How did it start? _____

Are you on any medications? _____

Please list all: _____

_____

Could you problem have been caused by an injury at work? _____

(If so please let the front desk know)

Have you been involved in an auto accident? _____

(If so please let the front desk know)

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 be aware of? _____

_____

_____

Signature: _____ Date: _____

THANK YOU!

For Women Only

Date of your last menstrual period: _____

Are you using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____