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: ____________

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!