

CONSULTATION AND HEALTH HISTORY
(PLEASE PRINT CLEARLY)

You came to our office for a reason. Please describe the:

1st Major complaint/Illness _____

Onset	Duration	Intensity	Frequency	Location	Radiation

Provoking/Palliative/Factors _____

Prior Interventions, Treatments, Medications, Secondary Complaint.

Quality/Character of Symptoms/Problem

Radiation of Symptoms _____
Severity _____
Time _____

2nd Complaint/Illness _____
3rd _____
4th _____
5th _____
6th _____
Other _____

If needed we may interact with your other physicians. Please provide the following information:

Name of Chiropractor _____
Name of Primary Care Physician _____
Name of Specialist 1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____
4. _____ Specialty _____

Family History: Paternal, Maternal, Sibling, Paternal Aunt/Uncle, Maternal Aunt/Uncle
Paternal Grandmother/Father, Maternal Grandmother/Father

Orthopedic-Arthritis, Scoliosis, Rheumatoid Arthritis _____
Neurology-MS, ALS _____
Pathology – Heart Disease, Cancer, Diabetes _____

Past Health History Please list any surgeries you've had:

Surgery	Date of Surgery

Allergies

Social History

Circle the use of: Over the counter/Prescription/Illegal Drugs/Alcohol/Tobacco