

Community Chiropractic Initial Consultation Form

Patient's Name:

Today's Date

Address

City

State

Zip

Phone Number:

Hobbies:

Have you ever been under Chiropractic care? ()Yes ()No If so, when and where?

Please describe your condition when it is at its worst:

Please circle the appropriate responses:

Overall Frequency of Complaint: (circle one please)

Constant-**100%** of the time Frequent-**75%** Intermittent- **50%** Occasional-**25%**

Overall Intensity of Complaint: (circle one please)

Minimal (An annoyance but has no effect on activity)

Slight (Tolerable with some impairment to activity)

Moderate (Tolerable with marked impairment to activity)

Severe (Intolerable and cannot perform any activities)

Is your problem affecting any other areas of your body? If yes, please explain:

Does it interfere with your normal daily activities (work, family, recreation)

What aggravate the problem?

What relieves the problem? (What have you tried for relief?)

If this went without care, how do you think it would affect you?

Do you have any questions or concerns?