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? _____

_____

Have you been injured at work?_____

_____

If yes, please give us the details: _____

_____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this?_____

_____

Use Alcohol?_____Use Street drugs?_____

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?_____

_____

_____

_____

_____

_ **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? _____

_____

What surgeries have you had: _____

Have you ever experienced any of the following:

Musculoskeletal System	**Genito-Urinary System**	**Gastro-Intestional System**
❑ Low back pain ❑ Mid back pain ❑ Pain between shoulders ❑ Neck pain ❑ Arm problems ❑ Leg problems ❑ Swollen joints ❑ Painful joints ❑ Stiff joints ❑ Sore muscles ❑ Weak muscles ❑ Walking problems ❑ Spasms ❑ Broken bones ❑ Shoulder pain	❑ Bladder control ❑ Excessive urination ❑ Scanty urination ❑ Painful urination ❑ Discoloured urination **Female** ❑ Vaginal discharge ❑ Vaginal bleeding ❑ Vaginal pain ❑ Breast pain ❑ Lumps on the breast	❑ Poor appetite ❑ Excessive hunger ❑ Difficult chewing ❑ Difficult swallowing ❑ Excessive thirst ❑ Nausea ❑ Vomiting blood ❑ Abdominal pain ❑ Diarrhea ❑ Constipation ❑ Black stool ❑ Bloody stool ❑ Hemorrhoids ❑ Liver trouble ❑ Gall bladder problems ❑ Weight trouble
Nervous System	**Cardio-Vascular Respiratory**	**Eye, Ear, Nose and Throat**
❑ Numbness ❑ Loss of feeling ❑ Paralysis ❑ Dizziness ❑ Fainting ❑ Headaches ❑ Muscles jerking ❑ Convulsions ❑ Forgetfulness ❑ Confusion ❑ Depression ❑ Insomnia ❑ Stroke or TIA's	❑ Chest pain ❑ Difficult breathing ❑ Persistent cough ❑ Coughing phlegm ❑ Coughing blood ❑ Rapid heartbeat ❑ Blood pressure problems ❑ Heart problems ❑ Lung problems ❑ Varicose veins	❑ Eye strain ❑ Eye inflammation ❑ Vision problems ❑ Ear pain ❑ Ear noises ❑ Ear discharge ❑ Hearing loss ❑ Nose pain ❑ Nose bleeding ❑ Nose discharge ❑ Difficulty breathing through nose ❑ Sore gums ❑ Dental problems ❑ Sore mouth / throat ❑ Hoarseness ❑ Difficult speech ❑ Sinus ❑ Allergy ❑ Jaw pain

SIGNATURE: _____ DATE: _____