Inline Chiropractic Group

Consultation History

Name_____Date_____

Reason for consulting our office. Please list your concerns/symptoms in order of severity:

1._____

For how long?_____How did it start?_____

2._____

For how long?_____How did it start?_____

How often is this problem present? ☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic

Is this condition getting worse? ☐ Yes ☐ No

What have you tried to do to get rid of this problem that **DID NOT WORK?**

☐ Medication ☐ Rest ☐ Stretching ☐ Exercise ☐ Taking it easy ☐ Physical Therapy ☐ Surgery

☐ Other_____

Have you become discouraged about handling this problem? ☐ Yes ☐ No

When your problem is at it's worst, how does it make you feel?_____

Does this problem cause you to be: ☐ Moody ☐ Irritable ☐ Interrupted Sleep ☐ Restricted from activity

☐ Stressed ☐ Lose Patience with Spouse or Children ☐ Other_____

Does this affect your work when it comes to ☐ Decision Making ☐ Attitude ☐ Decreased Productivity

☐ Exhausted at the End of the Day ☐ Unable to Work Long Hours

Give us some specific examples of how these problems interfere with the following areas of your life:

Work:_____ Family:_____

Hobbies:_____ Life:_____

What do you do that makes this problem worse?_____

What seems to give you some temporary relief?_____

Have you ever seen a Chiropractor before? ☐ Yes ☐ No If yes, when?_____

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

General History (Do you currently have or have ever had the following)

☐ Cancer (if so please explain)_____

☐ Broken Bones ☐ Numbness in Extremities ☐ Difficulty Sleeping ☐ Back Pain ☐Venereal Disease

☐ Fatigue ☐ Headaches ☐ HIV/AIDS ☐ Tension Across Shoulders ☐ Depression ☐Cold Hands/Feet

☐ Stress Problems ☐ Other:_____

Neurological Complaints **Name:** _____

Head & Neck
☐ None ☐ Double Vision ☐ Ear Ache ☐ Hearing loss ☐ Ringing in ears ☐ Chronic ear infections ☐ Hoarseness
☐ Difficulty Swallowing ☐ Sore Throat ☐ Other:_____

Cardiovascular
☐ None ☐ Palpitations ☐ Dizziness ☐ Hypertension ☐ Hypotension ☐ High Cholesterol ☐ Excessive Bruising
☐ Lower extremity edema ☐ Other:_____

Respiratory
☐ None ☐ Cough ☐ Shortness of Breath ☐ Asthma ☐ Sleep Apnea ☐ Emphysema ☐ Hay fever ☐ Pneumonia
☐ Wheezing ☐ Other:_____

Gastrointestinal
☐ None ☐ Nausea ☐ Abdominal Pain ☐ Heartburn ☐ Ulcer ☐ Food Sensitivities ☐ Changes in Bowels ☐ Constipation
☐ Diarrhea ☐ Blood in Stool ☐ Other:_____

Genitourinary
☐ None ☐ Dysuria ☐ Urinary Frequency ☐ Incontinence ☐ Blood in Urine ☐ Other:_____

Endocrine
☐ None ☐ Diabetes ☐ Cold Intolerance ☐ Hot Intolerance ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Other:_____

Dermatology
☐ None ☐ Rash ☐ Easy Bruising ☐ Bleeding Gums ☐ Blood in Stools ☐ Hyper pigmentation ☐ Hypo pigmentation
☐ Eczema ☐ Psoriasis ☐ Excessive Acne ☐ Skin Cancer ☐ Excessive Hair Loss ☐ Other:_____

Past History

Have you ever had any surgeries? ☐ No ☐ Yes:_____

Are you taking any medications? ☐ No ☐ Yes If yes, please list all medications/allergies on the form that is attached

Do you suffer from any current illnesses? ☐ No ☐ Yes:_____

Have you ever been in any accidents? ☐ No ☐ Yes:_____

Family History

Has anyone in your family had or suffer from…☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ High BP ☐ Parkinson's
☐ Alzheimer's ☐ Other:_____

Work History

Work Status? ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student ☐ Homemaker

How many hours per week do you work? ☐ None ☐ 0-20 ☐ 20-40 ☐ 40-50 ☐ 50-60 ☐ 60-70 ☐ More than 70

What do you do mostly at work? ☐ Stand ☐ Sit ☐ Walk Is your work load? - ☐ Light ☐ Moderate ☐ Heavy

How do you find your job? ☐ Difficult ☐ Enjoyable ☐ Relaxed ☐ Stressful ☐ Other:_____

Social History

Do you smoke? ☐ No ☐ Yes (How much?_____) Do you drink alcohol?☐ No ☐ Yes (How much?_____)

Do you drink caffeine? ☐ No ☐ Yes (How much?_____) Do you take any recreational drugs? ☐ No ☐ Yes

Do you exercise regularly? ☐ No ☐ Yes (How often?_____)

How many meals a day do you eat? ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4+ Do you take any natural supplements? ☐ No ☐ Yes

Is your current condition related to an on the job injury? ☐ No ☐ Yes Auto Accident? ☐ No ☐ Yes

Any other health problems or concerns that you have that are not mentioned on this form?_____
_____

_____ _____
Signature Guardian Signature, if a minor