Consultation

Performed by: _____
Date of Consult: _____

Is this condition due to: Your job? Y N
An auto accident? Y N

Current Complaints

1. What is the problem? _____
2. When did the problem begin? _____
3. How did the problem begin? _____
4. Did the problem begin: Gradually? Suddenly? _____
5. Is the problem: Getting better? Getting worse? Staying the same? Coming and going? Worse in the: Morning? Mid-day? Evening? Worse after: Exercise? Rest? _____
6. On a "0-10" pain scale, where "0"is no pain and "10" is the worst possible pain, how would you rate your problem: Now _____ At its worst? _____ On average? _____ Prior to DOI? _____
7. What increases the problem? _____
8. What decreases the problem? _____
9. Does this problem:
   - Wake you up at night? N O F C
   - Prevent you from sleeping? N O F C
   - Cause nausea/dizziness/vomiting? N O F C
   - Travel into your arm or leg? N O F C
10. Are you taking any medication for this problem? Y N If yes, which one(s)?_____
11. Have you seen anyone else for this problem? Y N If yes:
    When?_____
    What was the Dx?_____
    Any special tests? (x-rays, CT, MRI): Y N _____
    What Tx was done? _____
    Who treated you?_____
    Did your condition respond well to care? Y N _____
    Are you still under the care of this person? Y N _____
12. Have you missed any work as a result of your problem? Y N
    If yes, give dates missed: _____
13. Are you currently being treated for any other condition? Y N
    If yes, for what and by whom? _____
14. Have you had a recent cold, flu, or other infection? Y N
    If yes, when and has it gone away? Y N _____
15. What positon do you sleep in at night? Side / Back / Stomach
    Do you sleep on a firm surface? Y N _____
    Do you use a cervical pillow? Y N _____
16. Do you exercise on a regular basis? Y N If yes, what exercise and how often? _____
17. Comments:

Past Medical History

18. Have you ever had this or a similar problem in the past? Y N
    If yes: When?_____
    What was the Dx? _____
    How was it treated? _____
    By whom?_____
    Did it respond well to care?_____
    Were there any residuals?_____
19. Have you had any prior chiropractic/physiotherapy care? Y N
    If yes: When? _____
    What was the Dx? _____
    Who treated you? _____
    For how long? _____
    Did you respond well to care? _____
    Were there any residuals? _____
20. Have you had any surgeries? Y N If yes, what were they for and when did they occur? _____
21. Have you ever been hospitalized for any reason? Y N If yes, what for and when? _____
22. Have you ever had any fractures? Y N If yes, what kind, when, and what was done for it? _____
23. Have you ever been knocked unconscious? Y N If yes, when and how did it happen? _____
24. Do you have any allergies? Y N If yes, what are you allergic to? _____
25. Are you currently taking any medications? Y N _____
    If yes, which ones and what are they for? _____
26. Do you have a history of cancer, stroke, diabetes, high blood pressure, TMJ problem, or spinal abnormality? Y N If yes, what is the problem, when was it diagnosed, and what was done for it? _____
27. Have you ever had any other significant illnesses? Y N If yes, what were they and when did you have them? _____
28. Do you have any history, now or in the past, of having nausea, dizziness, or any other unusual sensation upon moving your head into certain positions? Y N If yes, what and when did it happen? _____
29. Is there anything else we need to know about your condition? Y N
    If yes, what is it? _____
30. Comments: