Life Chiropractic Center

Initial Consultation Form

Patient's Name: ______________________________ Date: ______________

Primary Complaint(s): ____

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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) **Moderate** (Tolerable, with marked impairment of activity)
Slight (Tolerable with some impairment to activity) **Severe** (Intolerable and cannot perform any activities)

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

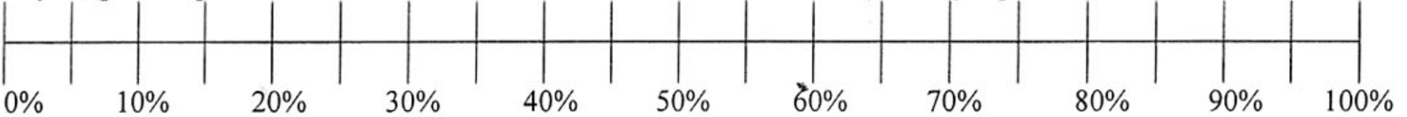
____

____

Does it interfere with your normal daily activities (Family, recreation, sports)? ______________
How? ____

____

Does your symptoms increase while performing your normal work duties? (Circle One) Y N
If yes, please place an "X" at the amount below that you feel your symptoms increase at work:



What aggravates the problem? _______________________________________

____

What relieves the problem? ____

____

If this went without being taken care of, how do you think it would affect you? ______________

____

Any questions or concerns? ____

____

______________________ ______________________
Patient's Signature Date

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