Health First Chiropractic Clinic, P.C.
"Caring for Your Health First"

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Consultation History

Name: _____ Date: _____

Mechanism of Injury (How did this injury happen):

No known injury	Fell	Lifting/Wrestling/ Playing with Children/Others	Reaching and pulling	Pushing
Auto accident	Lifting (Please Name) _____	Twisted	Yardwork	Exercising
Playing sports (Please Name) _____	Bent forward	Slipped on ice	Shoveling snow	Other: _____

Onset of Current Injury (When did this injury most recently occur):

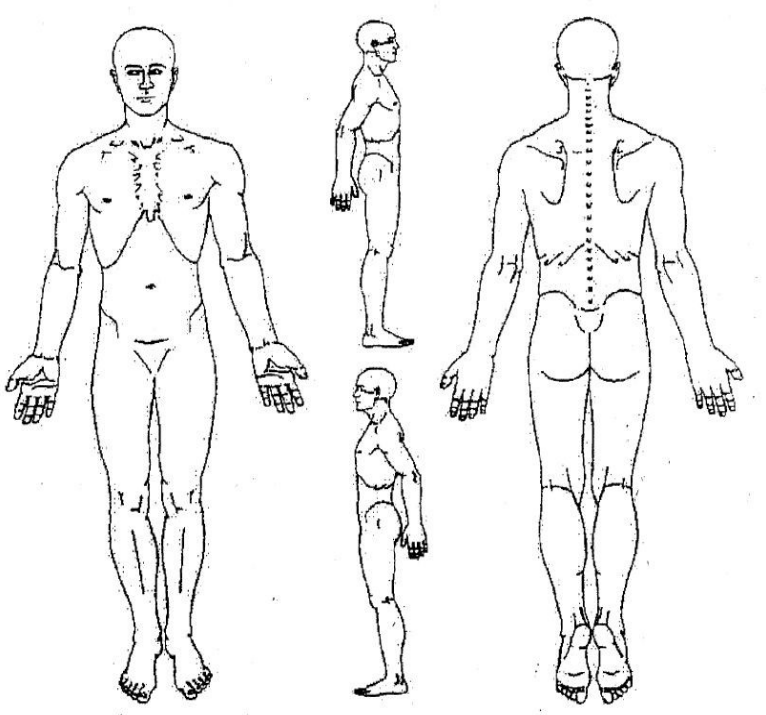
Less than 1	Hours
1, 2, 3	Days
4, 5, 6	Weeks
7, 8, 9, 10	Months

IF this injury has occurred before, *when* was the first occurrence*?* _____

On the diagram, please indicate where you have any complaints (Primary and secondary).

Please use the following key to mark exact locations of your pain.

P = Sharp Pain (*Default)*
D = Dull Pain
T = Tingling
N = Numbness
B = Burning
S = Stiffness
A = Achy



Please circle the severity of your symptoms on a scale of 0—10.

None 0 1 2 3 4 5 6 7 8 9 10 Extreme

#_____

Implemented 07/04/16

Name: _____ Date: _____

Are your symptoms constant? Yes No

If *No,* please complete the following sentence regarding the *frequency and duration* of your pain. Not all portions need to be completed.

My symptoms occurs _____ time(s),

Less than 1x 1—3x 4—6x 7—9x More than 10x

...on a _____ basis,

Daily Weekly Intermittent

...and lasts _____ (1)_____ _____(2) _____,

(1) Less than 1 1—5 5—10 10—30 More than 30

(2) Minutes Hours Days Variable, Cannot Determine

Are there any *aggravating* factors? (What makes the pain worse?)

Nothing	Bending or Twisting	Exercising	Lifting more than 10 lbs
	Pulling	Reaching	Lifting more than 20 lbs
	Walking	Sitting	Lifting more than 50 lbs
	Laying down	Standing	Other: _____

Are there any *relieving* factors? (What helps relieve the pain?)

Nothing	Heat or Ice	Prescription Drugs (Medical Marijuana, etc)	Non-Prescription Drugs (Tylenol, Advil, etc)
	Pillows	Rest	Laying down
	Sitting	Sleeping	Standing
	Stretching	Support Brace	Other: _____

Have you seen any other providers (MD, DO, DC, PT, Massage) for this injury? Yes No

If yes, please list: _____

Have there been any changes in your health history since this injury occurred? Yes No

If yes, please list: _____

Medical Affadavit: I do swear under oath, that the above information is true.

Patient Signature: _____ **Date:** _____

Review/Consult by Physician:_____

#_____

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