Chiropractic Consultation

Sound Chiropractic Center | 820 NE Northgate Way Seattle, WA 98125 | (206) 440-7700 FAX (206) 440-8900

PATIENT'S NAME: DATE:

REFERRAL:

DOCTOR:

MAJOR COMPLAINT:

STORY	RELEVANT TRAUMAS
COMPLAINTS	FAILED TREATMENT

WHEN FIRST NOTICED THIS:

HAS HAPPENED BEFORE:

WORSE/BETTER (AM/PM):

ANY RADIATION OF PAIN TO AN EXTREMITY? (WHERE):

ANY POSITION RELIEVES:

LOCATION:

TYPE:

FREQUENCY (PAIN):

DURATION (PAIN):

INTENSITY (PAIN):

OTHER DOCTORS SEEN FOR THIS CONDITION:

WHAT DONE FOR CONDITION YOURSELF; DID IT HELP:

MEDICATION TAKEN FOR THIS CONDITION:

ANYONE RECOMMEND MEDICATION? (yes/no)

ANYONE RECOMMEND SURGERY? (yes/no)

1. Patient's Diagnosis:

2. Rated 1 to 10 (Now/Worst):

3. Patient's Assessment:

NOTES:

SPINAL CORD PRESSURE

		Onset	Frequency	Duration	Intensity
1) (yes/no) (now/ever)	HEADACHES	O	F	D	I
2) (yes/no) (now/ever)	DIZZINESS	O	F	D	I
3) (yes/no) (now/ever)	BLURRED VISION	O	F	D	I
4) (yes/no) (now/ever)	LOSS/CONCEN.	O	F	D	I
5) (yes/no) (now/ever)	DEPRESSION	O	F	D	I
6) (yes/no) (now/ever)	NERVOUSNESS	O	F	D	I
7) (yes/no) (now/ever)	DIFFICULTY SLEEPING	O	F	D	I
8) (yes/no) (now/ever)	LOSS OF ENERGY	O	F	D	I
9) (yes/no) (now/ever)	TIRED AM	O	F	D	I
10) (yes/no) (now/ever)	BUZZ/RING/EAR	O	F	D	I
11) (yes/no) (now/ever)	RUN DOWN	O	F	D	I
12) (yes/no) (now/ever)	RAINTING	O	F	D	I
13) (yes/no) (now/ever)	PALPITATION	O	F	D	I

GENERAL PROBLEMS WITH FOLLOWING

1) (yes/no) (now/ever)	HEAD	O	F	D	I
2) (yes/no) (now/ever)	SINUS	O	F	D	I
3) (yes/no) (now/ever)	NECK PAIN/STIFFNESS	O	F	D	I
4) (yes/no) (now/ever)	SHOULDER PROBLEMS	O	F	D	I
5) (yes/no) (now/ever)	ARM PAIN (R/L)	O	F	D	I
6) (yes/no) (now/ever)	UPPER BACK	O	F	D	I
7) (yes/no) (now/ever)	MID BACK	O	F	D	I
8) (yes/no) (now/ever)	CHEST PAIN	O	F	D	I
9) (yes/no) (now/ever)	LUNG	O	F	D	I
10) (yes/no) (now/ever)	HEART	O	F	D	I
11) (yes/no) (now/ever)	STOMACH	O	F	D	I
12) (yes/no) (now/ever)	DIGESTION	O	F	D	I
13) (yes/no) (now/ever)	BLADDER	O	F	D	I
14) (yes/no) (now/ever)	LIVER	O	F	D	I
15) (yes/no) (now/ever)	KIDNEY	O	F	D	I
16) (yes/no) (now/ever)	COLON	O	F	D	I
17) (yes/no) (now/ever)	CONSTIPATION	O	F	D	I
18) (yes/no) (now/ever)	LOW BACK	O	F	D	I
19) (yes/no) (now/ever)	HIP	O	F	D	I
20) (yes/no) (now/ever)	LEG PAIN (R/L)	O	F	D	I
21) (yes/no) (now/ever)	POOR CIRCULATION	O	F	D	I

PREVIOUS INJURIES

1) HOSPITAL/SURGERY (yes/no):

2) ACCIDENTS (AUTO/FALLS) (yes/no):

3) ACCIDENT ON JOBS (yes/no):

4) MOTHER/FATHER FAMILY: