Patient Consultation

Patient:_____Birthdate:_____
First MI (initial) Last

Address:_____

Email:_____Phone#_____

General Health

Medical Conditions, check all that apply:

____Arthritis ____Osteoporosis ____Multiple Sclerosis ____Fibromyalgia ____Visual Problems
____Hearing Problems ____Panic Attacks/Anxiety ____Depression ____Allergies ____Cancer
____Blood Disorder ____Circ/Vascular Issues ____Hypertension ____High Chol/Lipids ____Diabetes
____Heart Disease ____Kidney Disease ____Lung Disease ____Liver Disease ____Thyroid Disease
____Stomach Disease/Reflux ____Infectious Disease ____Parkinsons Disease ____Stroke Paralysis
____Pacemaker ____Head Injury ____Migraines

___Recent Hospitalizations If yes explain:_____

___Surgery If yes Explain:_____

Key Questions on Condition

What is your main Complaint?_____

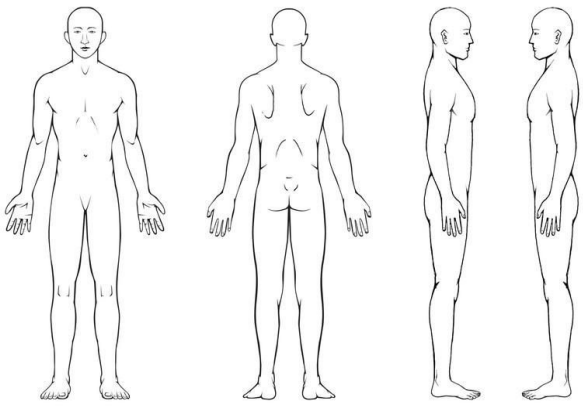
What caused your complaint?_____

When and how did these symptoms begin?_____

On a Scale of 1 (being low) to 10 (being high)

What is your level of pain at rest?_____
What is your pain with activity?_____
What is your level of pain now?_____
What is your pain level at its worst?_____
What is your pain level at its best?_____

Darken the areas on the body where you are having issues:



How would you describe your pain?
___Aching ___Burning ___Cramping ___Crushing
___Discomfort ___Dull ___Gnawing ___Numbness
___Loss of Sensation ___Pressure ___Sharp ___Tight
___Stabbing ___Stinging ___Swollen ___Throbbing
___Tingling ___Weakness ___Other:_____