

1. The symptom(s) that have prompted me to seek care today include: _____

Last Name _____

2. And are the result of (check one): An accident or injury
 Work Auto Other
 A worsening long-term problem
 An interest in: Wellness Other

3. Onset (When did you first notice your current symptoms?)

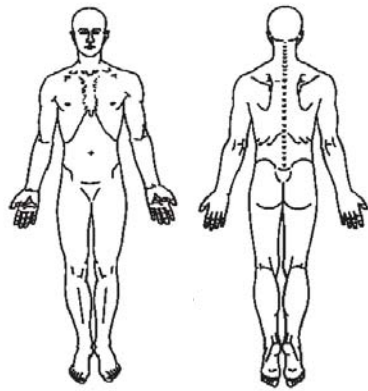
4. Intensity (How extreme are your current symptoms?)

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Come and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)
- Numbness
 - Tingling
 - Stiffness
 - Dull
 - Aching
 - Cramps
 - Nagging
 - Sharp
 - Burning
 - Shooting
 - Throbbing
 - Stabbing
 - Other

7. Location (Where does it hurt?)
Circle the area (s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
 Prescription medication Surgery Other _____
 Over-the-counter drugs Acupuncture _____
 Homeopathic remedies Chiropractic _____
 Physical therapy Massage _____

11. What else should Dr. Cormier know about your current condition? _____

12. How does your current condition interfere with your:
Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal
Had Have Osteoporosis Arthritis Scoliosis Neck pain Back problems Hip disorders
 Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture Initials _____

b. Neurological
Had Have Anxiety Depression Headache Dizziness Pins and needles Numbness Initials _____

c. Cardiovascular
Had Have High blood pressure Low blood pressure High cholesterol Poor circulation Angina Excessive bruising Initials _____

d. Respiratory
Had Have Asthma Apnea Emphysema Hay fever Shortness of breath Pneumonia Initials _____

e. Digestive
Had Have Anorexia/bulimia Ulcer Food sensitivities Heartburn Constipation Diarrhea Initials _____

f. Sensory
Had Have Blurred vision Ringing in ears Hearing loss Chronic ear infection Loss of smell Loss of taste Initials _____

g. Integumentary
Had Have Skin cancer Psoriasis Eczema Acne Hair loss Rash Initials _____

Consultation Notes

(Continues from previous page)

Last Name _____

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy Initials _____

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms Initials _____

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight Had Have Weakness Initials _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments.

PERSONAL	14. Illnesses	Check the illnesses you have Had in the past or Have now.	15. Operations	Surgical interventions, which may or may not have included hospitalization.	16. Treatments	Check the ones you've received in the Past or are receiving Currently .	
	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Past <input type="radio"/> Currently <input type="radio"/>	Past <input type="radio"/> Currently <input type="radio"/>	Past <input type="radio"/> Currently <input type="radio"/>	
	<input type="radio"/> <input type="radio"/> AIDS	<input type="radio"/> <input type="radio"/> Sexually transmitted disease	<input type="radio"/> <input type="radio"/> Appendix removal	<input type="radio"/> <input type="radio"/> Acupuncture	<input type="radio"/> <input type="radio"/> Alcoholism	<input type="radio"/> <input type="radio"/> Stroke	<input type="radio"/> <input type="radio"/> Antibiotics
	<input type="radio"/> <input type="radio"/> Allergies	<input type="radio"/> <input type="radio"/> Tuberculosis	<input type="radio"/> <input type="radio"/> Bypass surgery	<input type="radio"/> <input type="radio"/> Birth control pills	<input type="radio"/> <input type="radio"/> Arteriosclerosis	<input type="radio"/> <input type="radio"/> Typhoid fever	<input type="radio"/> <input type="radio"/> Blood transfusions
	<input type="radio"/> <input type="radio"/> Arthritis	<input type="radio"/> <input type="radio"/> Ulcer	<input type="radio"/> <input type="radio"/> Cancer	<input type="radio"/> <input type="radio"/> Chemotherapy	<input type="radio"/> <input type="radio"/> Cancer	<input type="radio"/> <input type="radio"/> Other: _____	<input type="radio"/> <input type="radio"/> Chiropractic care
	<input type="radio"/> <input type="radio"/> Chicken pox	_____	<input type="radio"/> <input type="radio"/> Elective surgery:	<input type="radio"/> <input type="radio"/> Dialysis	<input type="radio"/> <input type="radio"/> Cosmotic surgery	_____	<input type="radio"/> <input type="radio"/> Herbs
	<input type="radio"/> <input type="radio"/> Diabetes	_____	<input type="radio"/> <input type="radio"/> Eye surgery	<input type="radio"/> <input type="radio"/> Homeopathy	<input type="radio"/> <input type="radio"/> Eczema	_____	<input type="radio"/> <input type="radio"/> Hormone replacement
	<input type="radio"/> <input type="radio"/> Emphysema	_____	<input type="radio"/> <input type="radio"/> Hysterectomy	<input type="radio"/> <input type="radio"/> Inhaler	<input type="radio"/> <input type="radio"/> Epilepsy	_____	<input type="radio"/> <input type="radio"/> Massage therapy
	<input type="radio"/> <input type="radio"/> Glaucoma	_____	<input type="radio"/> <input type="radio"/> Pacemaker	<input type="radio"/> <input type="radio"/> Physical therapy	<input type="radio"/> <input type="radio"/> Gout	_____	<input type="radio"/> <input type="radio"/> Nutritional Supplements
	<input type="radio"/> <input type="radio"/> Heart disease	_____	<input type="radio"/> <input type="radio"/> Tonsillectomy	<input type="radio"/> <input type="radio"/> Medications (prescription and over-the-counter):	<input type="radio"/> <input type="radio"/> Hepatitis	_____	_____
	<input type="radio"/> <input type="radio"/> Malaria	_____	<input type="radio"/> <input type="radio"/> Vasectomy	_____	<input type="radio"/> <input type="radio"/> Measles	_____	_____
	<input type="radio"/> <input type="radio"/> Multiple Sclerosis	_____	<input type="radio"/> <input type="radio"/> Other: _____	_____	<input type="radio"/> <input type="radio"/> Mumps	_____	_____
	<input type="radio"/> <input type="radio"/> Pneumonia	_____	17. Injuries	Have you ever...	<input type="radio"/> <input type="radio"/> Used a crutch or other support	_____	_____
	<input type="radio"/> <input type="radio"/> Polio	_____	<input type="radio"/> <input type="radio"/> Had a fractured or broken bone	_____	<input type="radio"/> <input type="radio"/> Used neck or back bracing	_____	_____
	<input type="radio"/> <input type="radio"/> Rheumatic fever	_____	<input type="radio"/> <input type="radio"/> Had a spine or nerve disorder	_____	<input type="radio"/> <input type="radio"/> Received a tattoo	_____	_____
	<input type="radio"/> <input type="radio"/> Scarlet fever	_____	<input type="radio"/> <input type="radio"/> Been knocked unconscious	_____	<input type="radio"/> <input type="radio"/> Had a body piercing	_____	_____

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Cormier about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Dr. Cormier about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Hobbies: _____
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation? <input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress? <input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace? <input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated? <input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings? <input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs? <input type="radio"/> Yes <input type="radio"/> No

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Last Name _____

22. What is the major stressor in your life? _____
23. How much sleep do you average per night? Hours
24. What is the type and approximate age of your mattress and pillow? _____
25. What is your preferred sleeping position? _____
26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals
27. What would be the most significant thing that you could do to improve your health? _____
28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct Dr. Cormier to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not treat or cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

Signature

Date (MM/DD/YYYY)

Consultation Notes