

# Cartagine Chiropractic and Wellness



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## Adult Consultation History

Your Name: \_\_\_\_\_

Your Main Complaint: \_\_\_\_\_

Any other Complaints: \_\_\_\_\_  
\_\_\_\_\_

How long have you suffered with this problem? \_\_\_\_\_

What have you tried to do to get rid of this problem that **DID NOT** work? \_\_\_\_\_  
\_\_\_\_\_

Have you become discouraged about handling this problem? \_\_\_\_\_

When your problem is at its worst, how does it make you feel? \_\_\_\_\_  
\_\_\_\_\_

How does this problem interfere with the following areas of your life?

WORK: \_\_\_\_\_

FAMILY: \_\_\_\_\_

HOBBIES: \_\_\_\_\_

LIFE: \_\_\_\_\_

Does handling this problem cause stress for you? \_\_\_\_\_  
\_\_\_\_\_

What do you do that makes this problem worse? \_\_\_\_\_  
\_\_\_\_\_

How much older does this make you feel: \_\_\_\_\_

**On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem:** \_\_\_\_\_

What gives you some temporary relief? \_\_\_\_\_

What is the pattern of this problem?      Constant \_\_\_ Intermittent \_\_\_ Occasional \_\_\_ Cyclic \_\_\_

What is the effect it has on your body functions? \_\_\_\_\_

How did it start? \_\_\_\_\_

Are you on any type of medication? \_\_\_\_\_ Please list all: \_\_\_\_\_

Do you take vitamins, supplements or herbs? Please list all: \_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_ Please list: \_\_\_\_\_

Have you had prior traumas or injuries as a result of work, sport or hobby activity? \_\_\_\_\_

Have you had any other accidents or falls? \_\_\_\_\_

If yes, please give us the details: \_\_\_\_\_

Have you been involved in an auto accident? \_\_\_\_\_

Date of accident: \_\_\_\_\_

Do you have any difficulties from this? \_\_\_\_\_

Do you have any children? \_\_\_\_\_

Do they have any health problems that you are aware of? \_\_\_\_\_

Is there any other information you would like us to know? \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Thank You!**