ADULT CONSULTATION HISTORY

Name: _____

Primary Complaint:

_____

Secondary Complaint:

_____

How long have you suffered with this problem? _____

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

_____

_____

_____

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:

_____

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

How did it start?

_____

Could your problem have been caused by an injury at work? ❑ Yes ❑ No

If yes, please give us the details:

_____

_____

Have you been involved in an auto accident? ❑ Yes ❑ No If yes, date of accident: _____