Consultation Form

Please fill this form. We protect your privacy and maintain confidentiality in accordance with local and federal guidelines and regulations.

Name ____________________ DOB ____________

Phone (Mobile) ____________________ Email Address ____________________

Address ____________________ City ____________

State ______ Zip ____________ How did you hear about us? ____________________

Occupation ____________________

For Women: Are you pregnant? ❒ Yes ❒ No

Please check off any of the following where you experience pain or any conditions you suffer from:

- ❒ Headache
- ❒ Knee pain/degenerative disease
- ❒ Lower back or neck pain
- ❒ Arthritis
- ❒ Digestion symptoms
- ❒ Cardiovascular Problems
- ❒ Hypertension
- ❒ Anxiety and/or depression
- ❒ Diabetes
- ❒ Forgetfulness or memory decline
- ❒ Fatigue
- ❒ Breathing problems
- ❒ Sleep problems
- ❒ Nerve pain or neuropathy
- ❒ Skin related issue

Other Joint Pain: which joints? ____________________

Any other health conditions not listed above? Please add below.

____

Which of the above is the worst?

____

How long have you been suffering or struggling with this condition?

____

How often does it occur? (daily, weekly, monthly?)

____

What is your pain on a scale of (1=mild, 10=severe)? ____________________

What have you tried that did not help? ____________________

How do you see your life in 3 years if the problem/s will get worse?

____

How would your life be if this/these problem/s will improve or resolve?

____

Does this cause you to suffer from?

- ❒ Irritability or anger
- ❒ Interrupted sleep
- ❒ Restricted daily activity
- ❒ Feeling frustrated or experience mood disorder
- ❒ Fatigue
- ❒ Decline in physical activity

Does this affect your life?

- ❒ Holds me back from enjoying my family or friends
- ❒ Affects my ability to work (or provide income)
- ❒ Restricts my productivity or household duties
- ❒ Prevents me from exercising or practicing sports
- ❒ Interferes with my ability to enjoy my hobbies

I understand the purpose of the consultation is to better understand my health concerns. I understand that this consultation is not a medical evaluation or treatment and does not establish a provider-patient relationship.

Name ____________________ Date ____________

Signature ____________________