Initial Consultation

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Patient's Name: _____ Date: _____

Primary Complaint(s): _____

_____

_____

Please describe your condition when it is at its worse: _____

_____

_____

Overall Frequency of Complaint: (check one please)

☐ Constant *100% of the time* ☐ Frequent *75% of the time* ☐ Intermittent *50% of the time* ☐ Occasional *25% of the time*

Overall Intensity of Complaint: (check one please)

☐ Minimal *(An annoyance but has no effect on activity)*

☐ Slight *(Tolerable with some Impairment to activity)*

☐ Moderate *(Tolerable with marked Impairment to activity)*

☐ Severe *(Intolerable and cannot perform any activities)*

Is your problem affecting any other area of your body?_____ If yes, please explain: _____

_____

_____

Does it interfere with your normal daily activities (Work, family, recreation)?_____ How?_____

_____

What aggravates the problem?_____

_____

What relieves the problem? (What have you tried for relief)? _____

_____

If this went without being taken cared of, How do you think it would affect you? _____

_____

Do you have questions or concerns? _____

_____

Signature: _____ Date:_____