

MOSSUTO CHIROPRACTIC CENTER
INITIAL CONSULT FORM

Name: _____ Date: _____

Primary Complaint: _____

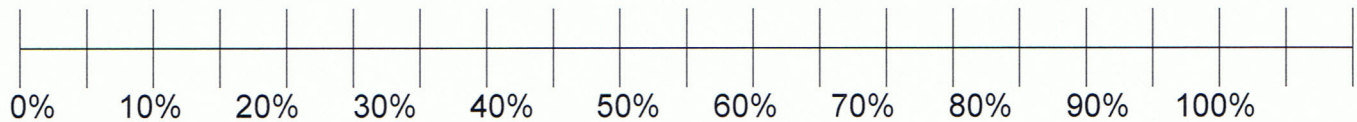
Please describe your condition when it is at its worst:

How long have you had this? (i.e. years, months, weeks, etc)

Was there an event that occurred at that time? (i.e. accident, fall, etc.) YES / NO (circle one)

Do your symptoms increase while performing your normal work duties? YES / NO (circle one)

If yes, please place an "x" at the amount below that you feel your symptoms increase at work:



Overall Frequency of Complaint: (please circle appropriate response)

Constant-100%

Frequent-75%

Intermittent-50%

Occasional-25%

Overall Intensity of Complaint: (please circle appropriate response)

Minimal- An Annoyance but has no effect on activity

Slight - Tolerable with some impairment to activity

Moderate - Tolerable with marked impairment of activity

Severe - Intolerable and cannot perform any activities

Is there any radiation or numbness/pain to arms or legs? If yes, please describe: _____

Does this problem affect any other areas of your body? If yes, please describe: _____

Does it interfere with your normal daily activities? (Work, family, recreation) YES / NO (circle one)

How? _____

What aggravates the problem?

What relieves the problem?

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

Any questions or concerns _____

Family Health Profile – In our office, we are not only interested in your health & well being, but also in that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Parents _____
Siblings _____
Others _____

The Beginning Years – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History Please check all those items that apply to you:

____ Mother smoked/drank/drugs in pregnancy ____ Epidural/Meds in labor
____ Breech Vaginal Delivery ____ C-Section ____ Forceps Delivery
____ Vacuum Extractor used ____ Labor Induced ____ Complications ____ Other

Childhood Years (Age 0 to 17 yrs) Please check all those items that apply to you:

____ Childhood Illness ____ Serious Falls ____ Active in Sports ____ Very Inactive
____ Car Accident(s) ____ Surgery/Stitches ____ Alcohol/Drug Abuse ____ Smoker
____ Antibiotics/Other Meds ____ Vaccinated ____ Under Chiropractic care ____ Broken Bones
____ Severe Emotional Trauma

Adult Years (18 Years to Present) Please check all those items that apply to you:

____ Present Smoker ____ Former Smoker ____ OTC Prescription Meds
____ Drug/Alcohol Use ____ Play Sports ____ Surgery/Stitches ____ Car Accidents
____ High Personal Stress ____ Work Injury ____ High Job Stress ____ Sit a Lot
____ Drive a Lot ____ Poor/Inadequate Diet ____ No Exercise ____ Poor Sleep
____ Flat Feet ____ Wear Orthotics/Lifts ____ Severe Health Problems ____ Hard Falls
____ Broken Bones ____ Other
____ Have been under chiropractic care in the past – How long ago was your last adjustment?

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Signature

Date