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:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

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