



## Initial Consultation Questionnaire

Answer Each Question by Printing the Necessary Information. Your Answers are Confidential.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

In Case of an Emergency, please notify:

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

How did you hear about us?

\_\_\_\_\_

### Medical Information

What is your primary concern? \_\_\_\_\_

Briefly describe the present symptoms you are experiencing:

\_\_\_\_\_

Have you tried anything to resolve the issue (if so, what?) \_\_\_\_\_

Please list any current Physicians below including Primary and any Specialists:

Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Physician \_\_\_\_\_ Phone: \_\_\_\_\_

What is your height? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

Are you under the care of a Physician, Chiropractor, or other healthcare professional for any reason?

Yes Please Indicate Reason(s) \_\_\_\_\_

No \_\_\_\_\_



Are you taking any medications, supplements or essential oils?  Yes  No If yes, Please list below

Type:

Dosage/Frequency:

Reason for Taking:

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Please list any allergies: \_\_\_\_\_

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Has your doctor said your blood pressure was too high?  Yes  No

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?  Yes  No

Are you over the age of 65  Yes  No

Are you accustomed to vigorous exercise?  Yes  No

Is there any reason not mentioned why you should not follow a regular exercise program? If yes, please explain. \_\_\_\_\_  Yes  No

Have you recently experienced any chest pain associated with either exercise or stress? If yes, please explain. \_\_\_\_\_  Yes  No

How often were you sick last year (with the flu, a cold, etc.)? \_\_\_\_\_

Would you consider your daily energy level low, medium, or high? \_\_\_\_\_

### **Personal & Family Medical History**

Please check all that apply and indicate yourself and/or family member ( i.e. *Aunt, Mother, Sister*) who is/has experienced each condition and/or type where indicated.

\_\_\_\_\_ Respiratory /Pulmonary Conditions: \_\_\_\_\_

\_\_\_\_\_ Diabetes: Type 1: \_\_\_\_\_ Type 2: \_\_\_\_\_ How Long \_\_\_\_\_

\_\_\_\_\_ Epilepsy: Petite Mal: \_\_\_\_\_ Grand Mal: \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Osteoporosis: \_\_\_\_\_

\_\_\_\_\_ High Blood Pressure: \_\_\_\_\_



\_\_\_\_\_ High Cholesterol: \_\_\_\_\_  
\_\_\_\_\_ Heart Disease: \_\_\_\_\_  
\_\_\_\_\_ Heart Attack: \_\_\_\_\_  
\_\_\_\_\_ Angina: \_\_\_\_\_  
\_\_\_\_\_ Anemia: \_\_\_\_\_  
\_\_\_\_\_ Stroke: \_\_\_\_\_  
\_\_\_\_\_ Gout: \_\_\_\_\_  
\_\_\_\_\_ Cancer/Type: \_\_\_\_\_

**Personal & Family Medical History (Continued)**

Please check all that apply and indicate yourself and/or family member ( i.e. *Aunt, Mother, Sister*) who is/has experienced each condition and/or type where indicated.

\_\_\_\_\_ Skin Condition/Type: \_\_\_\_\_  
\_\_\_\_\_ Kidney/Urinary Issues/ Type: \_\_\_\_\_  
\_\_\_\_\_ Liver Disease or Disorders / Type: \_\_\_\_\_  
\_\_\_\_\_ Blood Disorders / Type: \_\_\_\_\_  
\_\_\_\_\_ Autoimmune/Type: \_\_\_\_\_  
\_\_\_\_\_ Thyroid Disorder/Type: \_\_\_\_\_  
\_\_\_\_\_ Gastrointestinal Disorder/Type: \_\_\_\_\_  
\_\_\_\_\_ Mental/Emotional Disorders/Type: \_\_\_\_\_  
\_\_\_\_\_ Hypoglycemia: \_\_\_\_\_  
\_\_\_\_\_ Pregnancy (Pre/Postnatal): \_\_\_\_\_  
\_\_\_\_\_ Menopausal (Peri/Post): \_\_\_\_\_

**Musculoskeletal Information**

Please check / describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort.

\_\_\_\_\_ Head/Neck: \_\_\_\_\_  
\_\_\_\_\_ Upper/Lower Back: \_\_\_\_\_  
\_\_\_\_\_ Shoulder/Clavicle: \_\_\_\_\_  
\_\_\_\_\_ Arm/Elbow: \_\_\_\_\_  
\_\_\_\_\_ Wrist/Hand: \_\_\_\_\_



\_\_\_\_ Hip/Pelvis: \_\_\_\_\_  
\_\_\_\_ Thigh/Knee: \_\_\_\_\_  
\_\_\_\_ Arthritis: \_\_\_\_\_  
\_\_\_\_ Hernia: \_\_\_\_\_  
\_\_\_\_ Surgeries: \_\_\_\_\_  
\_\_\_\_ Other: \_\_\_\_\_

**Lifestyle & Nutritional Information**

What are your long-term health and wellness goals? \_\_\_\_\_  
\_\_\_\_\_

Are you on any specific food/diet plan at this time?       Yes     No  
If yes, please list: \_\_\_\_\_

Do you take dietary supplements, herbal products and/or essential oils?       Yes     No  
If yes, please list: \_\_\_\_\_

Do you experience any frequent weight fluctuations?       Yes     No

Have you experienced a recent weight gain or loss?       Yes     No  
If yes, list change and over how long: \_\_\_\_\_

How many beverages do you consume per day that contain caffeine? \_\_\_\_\_

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How would you describe your current nutritional habits? \_\_\_\_\_

Are there any other food/nutritional issues you want to include (food allergies, mealtimes, etc.) \_\_\_\_\_  
\_\_\_\_\_

Please indicate which best describes your habits concerning smoking:

\_\_\_\_ Non-user, or if former user, date quit: \_\_\_\_\_

\_\_\_\_ Cigar and/or pipe

\_\_\_\_ Less than 10 cigarettes per day

\_\_\_\_ 10 to 20 cigarettes per day

\_\_\_\_ More than 20 cigarettes per day



**Work & Exercise Habits**

Please indicate which best describes your work and exercise habits:

- \_\_\_\_\_ Intense occupational and recreational exertion
- \_\_\_\_\_ Moderate occupational and recreational exertion
- \_\_\_\_\_ Sedentary occupational and intense recreational exertion
- \_\_\_\_\_ Sedentary occupational and moderate recreational exertion
- \_\_\_\_\_ Sedentary occupational and light recreational exertion
- \_\_\_\_\_ Complete lack of all exertion

What is your occupation? \_\_\_\_\_

Do you work more than 40 hours per week?  Yes  No

**Work & Exercise Habits Continued**

To what degree do you perceive your environment as stressful?

Work: Minimal \_\_\_\_\_ Moderate \_\_\_\_\_ Average \_\_\_\_\_ Extremely \_\_\_\_\_

Home: Minimal \_\_\_\_\_ Moderate \_\_\_\_\_ Average \_\_\_\_\_ Extremely \_\_\_\_\_

Please list any other questions or comments you may have concerning your health and wellness:

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Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_