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:

_____

_____

_____

Please list any allergies:_____

_____

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:

_____

_____

_____

_____

Name:_____

Signature:_____ Date: _____