# Consultation Admittance Record

*(Please Print)*

Today's Date

1. Name ______________________ 2. Address ______________________
Apt No ________ City ______________ Zip ________ 3. Home Phone ______________
Bus Phone ________ Ext ______ 4. Age ______ Mo ____ Day ____ Yr ____ 5. Sex ___M ___ F
6. Marital Status M S W D _____7. Social Security No ________ 8.Occupation ____________ Yrs ______
9. Employer ______________10. Address ________________ Zip ________
11. Name of Spouse ______________________ 12. Spouse Employer ______________
Address ______________________City ______________Zip ________
13. Insurance Name ______________________ Contract No ______________
Name ____________ C No ____________ Name ____________ C No ____________
14. Previous Chiropractic Care ___ Yes ___ No 15. Referred By____________ 16. If Complaint is Result of an Injury, Check Box ❑

## MAJOR COMPLAINT

17. Describe Your Major Complaint in Detail ______________________

Date When The Condition First Started ______________ If Known, State Cause of Pain ______________

| Is This Condition | Getting Worse ____ | Getting Better ____ | Staying Same ____ | What Movements Or Positions Aggravate This Condition?______________ |
|---|---|---|---|---|

What Relieves The Pain ______________________
18. Have You Been Treated For Present Condition ____ Yes ____ No If Yes, When?______________
Name And Address Of Treating Dr. ______________________
What Was Done ______________________
Reason For Transferring From Previous Treating Dr. ______________________
19. Have You Had A Similar Condition Before ________ If Yes, When? ____________ Were You Treated ____________
Who Treated You ______________Street ______________ City ____________
20. Are You Working ______________ 21. If No, When Was Last Date Worked ______________
22. List Previous Injuries & Date ______________________
23. List All Previous Operations and Date______________________
24. List Major Illness and Date ______________________
25. List Present Medications______________________
26. Are You Pregnant ?_____ Yes _____ No

Patient's Signature ______________________

***(Payment is expected at time of visit unless other arrangements have been made in advance.)***

Previous Chiropractic Care: ❑ Yes ❑ No

If yes, details: Past DC ____________________ Last Adj. ________________ Frequency ________________

Satisfied/Helped __________ Type of care ______________Reason for discontinued care ______________

Positive: ______________________________________________________________________________

Negative:______________________________________________________________________________

**When your pain (Core 1,2,3) is at its worst, how does it affect or interfere with your normal activities of daily living?** ***Such as...***

**Self Care:** has your condition/pain interfered with your ability to take care of yourself, your ability to dress, shower, drive the car, fall or stay asleep? ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Mental State:** has your condition/pain affected your ability to concentrate and focus, has it caused depression, anxiety, anger, lack of motivation, fatigue, frustration, etc...? ______________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Recreation:** has you condition/pain limited your ability to participate in hobbies, sports, physical fitness, or other leisure time activities? ______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Work or School:** has your condition/pain made you less effective or productive at work or school? If yes, has it caused you to miss any days at school, work, or affected your income yet? ___________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Family/Home Responsibilities:** has this limited your ability to do chores around the house, yard work, dishes, grocery shopping, caring or playing with the children, or your relationship with your spouse? ________

______________________________________________________________________________

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______________________________________________________________________________

Is there anything else that you can think of that you haven't told me that I should know? ___________________

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