

EXTENDED CONSULTATION WORKSHEET

Today's date: _____

Name: _____ Date of Birth: _____

Your address: _____

City: _____ State: _____ Zip: _____

Gender (please circle): male / female Social Security Number: _____ - _____ - _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext _____

Email Address: _____

Employer (s): _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Occupation (s): _____

Marital Status (please circle): married divorced/separated never married widowed

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Work Phone: (____) _____

CONSENT TO TREATMENT OF MINOR CHILD

I here by authorize Dr. Hall to administer chiropractic care as deemed necessary to my

(circle one): son / daughter _____

Name of Child

on this day _____, 20____.

Date

Month

year

Signed: _____

Parent or Legal Guardian

HISTORY

When did condition(s) begin and how? _____

List your current condition(s) or symptom(s) in the order of decreasing severity:

1. _____

Duration: _____ Frequency: _____

2. _____

Duration: _____ Frequency: _____

3. _____

Duration: _____ Frequency: _____

4. _____

Duration: _____ Frequency: _____

5. _____

Duration: _____ Frequency: _____

6. _____

Duration: _____ Frequency: _____

7. _____

Duration: _____ Frequency: _____

8. _____

Duration: _____ Frequency: _____

PRIOR MEDICAL CARE:

Please list all surgeries and approximate dates:

Date	Type of Surgery	Post-operative complication(s)

Of the following diagnostic procedures, please indicate those you have undergone:

Study	No	Yes	Date	Results
Reg. Spine x-rays				
MRI				
CT Scan				
Bone Scan				
EMG				
Nerve Block				
Other: _____	N/A			

History of fractures:

Date	Fracture	Complications

LIFESTYLE HISTORY:

Do you (or have you) ever smoked cigarettes, cigars, a pipe, or used chewing tobacco? Yes / No

If yes, how many years? _____ If yes, what is the frequency during an average day? _____

If yes, what age were you when you quit? _____ N/A because I have not quit.

Do you drink alcoholic beverages? Yes / No

If yes, for how many years? _____ If yes, average number of drinks per week: _____

Have you ever used alcohol to control your pain? Yes / No

HISTORY OF PREVIOUS CONDITION(S):

Prior to this current condition(s), have you ever had similar condition that required professional help? Yes / No

If yes, briefly explain: _____

Other than this current condition, have you ever had any previous neck or back symptoms, that required professional help? Yes / No

If yes, briefly explain: _____

(continued on next page)

OCCUPATIONAL HISTORY:

How physically demanding is your job?

- Very heavy (frequently lifting 100 or more pounds)
- Heavy (frequently lifting 60 – 100 pounds)
- Moderate (frequently lifting 30 – 60 pounds)
- Light (frequently lifting 10 – 30 pounds)
- Sedentary (essentially no lifting)

Your work status at time of onset of this condition(s)

- Regular duties (full time)
- Temporary light duties
- Permanent light duties
- Not currently in work force
- On disability or time loss
- On public assistance

How satisfied are you with your job?

- Very satisfied
- Satisfied
- Dissatisfied
- It is the worst job I have had

When was the last time you worked?

- Today
- Yesterday
- Last week
- Last month
- Last year

Other: _____

Has your employer treated you fairly? Yes / No

FEMALES ONLY:

Indicate all that apply:

- Vaginal bleeding other than time of menstrual cycle
- Obstetrician/gynecological exam within the last two years.
- Currently having painful menstrual cycles that interfere with daily life
- Back pain increases with menstrual cycles.
- I have other menstrual problems
- I may be or I am currently pregnant. Approximate due date: _____

Signature: _____
(Please sign whether pregnant or not)