Consultation Form

RIVER VALLEY CHIROPRACTIC

First Name (Print) | Last Name (Print) | Age | Sex

Address | City | State | Zip Code

Phone (Home) | Phone (Work) | Phone (Cell)

E-mail Address | Date

Referral | Nationality | Occupation

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them *directly opposite* on the right side. Be sure to mention any drugs, vitamin supplements, or other medicinal substances you are taking.

Complaints:	**How long have you had it?**	**Treatment:**

RIVER VALLEY
CHIROPRACTIC

Brief Health History: (list major diseases, surgeries, etc.)

How many times per year do you get a cold or the flu? _____

Family Medical History:

What other medication and/or supplements are you taking?	How long have you taken them?

RIVER VALLEY CHIROPRACTIC

Emotions: **Normal**___ **Problem**___

Sadness ___ Anxiety ___

Depression ___ Panic attack ___ Sensitive ___ Worries ___ Overly Excited ___ Angry___

Describe: _____

_____

Energy: **Normal**___ **Problem**___

Low ___ Up and down ___ Exhausted ___ Hyperactive___ Nervous energy ___ Abundant ___

Describe: _____

_____

Sleep Pattern: **Normal**___ **Insomnia**___

Falling asleep: Sometimes difficult ___ Always difficult___

Sometimes very difficult___ Always very difficult___

Sleepy in daytime ___ Take naps___

Waking up: Times per night ___ Wake up too early___

Wake up at night and cannot go back to sleep again ___

Sleep Quality: **Deep** ___ **Light** ___ **Bad** ___

Many dreams ___ Bad dreams ___ Grinding teeth ___ Talking in sleep ___ Other ___

Describe: _____

_____

Sensitivity and Allergy: **Yes**___ **No** ___

Temperature: Cold ___ Hot ___ Dampness ___ Light ___ Noise ___ Airborne Particles___

Other ___ Drugs ___

Describe: _____

_____

Appetite and Digestion: **Normal**___ **Abnormal**___

Rapid hungering ___ Poor appetite ___ Nausea ___ Anorexia ___ Hungry, but no desire to eat___

Bloating ___ Gas___ Other ___

Describe: _____

_____

RIVER VALLEY CHIROPRACTIC

Menstrual Cycle:

Age of onset: ____ years Date of last period / /

Regular ____ **Irregular**____

How many days per cycle? ____ How many days did it last? ____

Color: Pale red____ Bright red ____ Purplish ____

Were there clots? Yes____ No ____

Menstrual Pain: **Yes**____ **No** ____

Before flow ____ During flow ____ After flow ____ Abdomen ____ Back____ Breast ____

Emotion around period: **Normal**____ **Abnormal**____

Before flow ____ During flow ____ After flow ____ Depression ____ Anger____

Sadness ____ Crying____ Other____

Describe:_____

_____

Bowel Movement:

Normal____ **Abnormal**____ **Time of Day**_____ am / pm

Constipation ____ Diarrhea____ Loose____ Incomplete____ Hard and dry ____ Strong Smell ____ Watery____

With Mucus ____ With blood____ Other____ **Describe:**_____

Body Weight:

Normal____ **Overweight**____ **Underweight**____

If overweight:

How many pounds would you like lose? ____

How many years ago did you first start to gain weight? ____

Are you following a weight control program?? ____

Describe:_____

Drinking:

Normal____ **Abnormal**____

Thirsty ____ Dry mouth ____ Drink a lot ____ Dry mouth but no desire to drink. ____

Not thirsty, but drink a lot anyway.____ **Describe:**_____

_____

Urination:

Normal____ **Abnormal**____

Frequent ____ Urgent ____ Burning ____ Painful ____ Cloudy ____ Dark Color ____ Foul Smell ____

Bloody ____ Difficult ____ Retention ____ Other____

Number of times per day ____ Number of times you get up to urinate at night ____

Describe:_____

Eye, Ear, and Nose:

Normal____ **Abnormal**____

Describe:_____

RIVER VALLEY
CHIROPRACTIC

Sex Function: **Normal___** **Abnormal___**

Describe: _____

Addictions: Tobacco ____ Alcohol ____ Other____

Describe: _____

Any other disorders or abnormalities:

Describe: _____