# Consultation Form

Please fill this form. We protect your privacy and maintain confidentiality in accordance with local and federal guidelines and regulations.

Name _____ DOB _____

Phone (Mobile) _____ Email Address _____

Address _____ City _____

State _____ Zip _____ How did you hear about us? _____

Occupation _____

For Women: Are you pregnant? ❒ Yes ❒ No

**Please check off any of the following where you experience pain or any conditions you suffer from:**

❒ Headache
❒ Knee pain/degenerative disease
❒ Lower back or neck pain
❒ Arthritis
❒ Digestion symptoms
❒ Cardiovascular Problems
❒ Hypertension
❒ Anxiety and/or depression
❒ Diabetes
❒ Forgetfulness or memory decline
❒ Fatigue
❒ Breathing problems
❒ Sleep problems
❒ Nerve pain or neuropathy
❒ Skin related issue

Other Joint Pain: which joints? _____

**Any other health conditions not listed above? Please add below.**

_____

**Which of the above is the worst?**

_____

**How long have you been suffering or struggling with this condition?**

_____

**How often does it occur? (daily, weekly, monthly?)**

_____

**What is your pain on a scale of (1=mild, 10=severe)?** _____

**What have you tried that did not help?** _____

**How do you see your life in 3 years if the problem/s will get worse?**

_____

**How would your life be if this/these problem/s will improve or resolve?**

_____

**Does this cause you to suffer from?**

❒ Irritability or anger
❒ Interrupted sleep
❒ Restricted daily activity
❒ Feeling frustrated or experience mood disorder
❒ Fatigue
❒ Decline in physical activity

**Does this affect your life?**

❒ Holds me back from enjoying my family or friends
❒ Affects my ability to work (or provide income)
❒ Restricts my productivity or household duties
❒ Prevents me from exercising or practicing sports
❒ Interferes with my ability to enjoy my hobbies

I understand the purpose of the consultation is to better understand my health concerns. I understand that this consultation is not a medical evaluation or treatment and does not establish a provider-patient relationship.

Name _____ Date _____

Signature _____