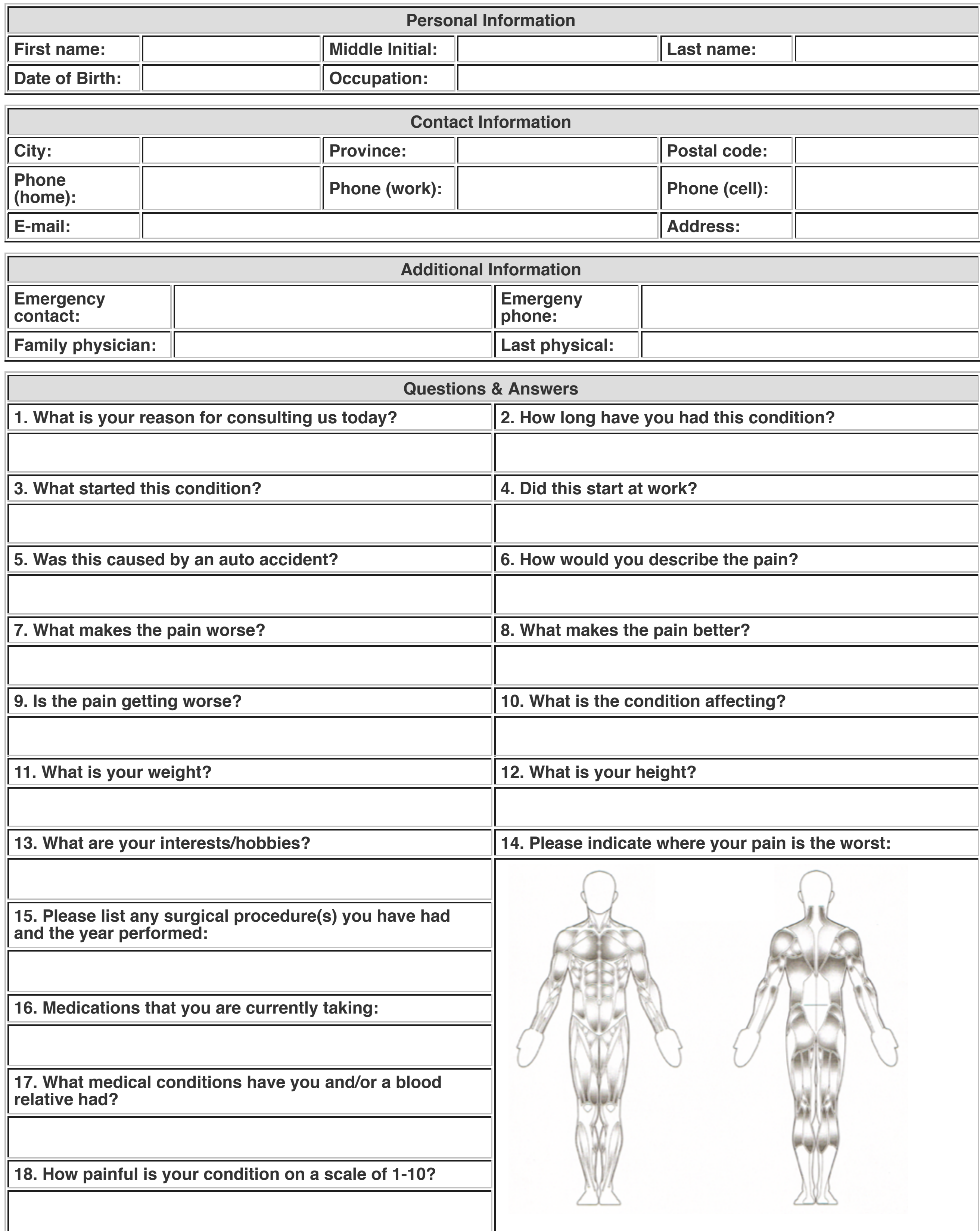

Consultation Form

Personal Information					
First name:		Middle Initial:		Last name:	
Date of Birth:		Occupation:			

Contact Information					
City:		Province:		Postal code:	
Phone (home):		Phone (work):		Phone (cell):	
E-mail:				Address:	

Additional Information			
Emergency contact:		Emergeny phone:	
Family physician:		Last physical:	

Questions & Answers	
1. What is your reason for consulting us today?	2. How long have you had this condition?
3. What started this condition?	4. Did this start at work?
5. Was this caused by an auto accident?	6. How would you describe the pain?
7. What makes the pain worse?	8. What makes the pain better?
9. Is the pain getting worse?	10. What is the condition affecting?
11. What is your weight?	12. What is your height?
13. What are your interests/hobbies?	14. Please indicate where your pain is the worst:
15. Please list any surgical procedure(s) you have had and the year performed:	
16. Medications that you are currently taking:	
17. What medical conditions have you and/or a blood relative had?	
18. How painful is your condition on a scale of 1-10?	