

**INITIAL CONSULTATION FORM**  
**PLEASE PRINT CLEARLY**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Dominant Hand     Right     Left     Both  
New Injury                      Re-examination                      Update                      Discharge Examination

Description/Onset: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**PRESENTING CONDITION**

**Primary Complaint:** \_\_\_\_\_  
**Date of Onset:** \_\_\_\_\_ **Type of Onset:**    Sudden    Gradual    Traumatic    Chronic    Unknown  
**Type of Pain:**    Dull Ache    Sharp    Shooting    Stiffness    Numbness    Tingling    Weakness    Throbbing    Burning  
**Pain Frequency:**    Constant (76-100% of the day)    Frequent (51-75%)    Occasional (26-50% )    Intermittent (0-25%)  
**Pain Intensity:**    Minimal    Slight    Moderate    Severe                      Pain Rating (1-10): \_\_\_\_\_  
**Radiation:**    Head \_\_\_    Neck \_\_\_    Shoulder \_\_\_    Arm \_\_\_    Hand \_\_\_    Buttock \_\_\_    Hip \_\_\_    Leg \_\_\_    Foot \_\_\_  
**Aggravated by:**    AM    PM    Sleeping    Bending    Twisting    Standing    Sitting    Lifting    Cough/Sneezing    Stress  
**Relieved by:**    AM    PM    Sleeping    Bending    Twisting    Standing    Sitting    Lifting    Cough/Sneezing    Stress  
**Explain:** \_\_\_\_\_

**Second Complaint:** \_\_\_\_\_  
**Date of Onset:** \_\_\_\_\_ **Type of Onset:**    Sudden    Gradual    Traumatic    Chronic    Unknown  
**Type of Pain:**    Dull Ache    Sharp    Shooting    Stiffness    Numbness    Tingling    Weakness    Throbbing    Burning  
**Pain Frequency:**    Constant (76-100% of the day)    Frequent (51-75%)    Occasional (26-50% )    Intermittent (0-25%)  
**Pain Intensity:**    Minimal    Slight    Moderate    Severe                      Pain Rating (1-10): \_\_\_\_\_  
**Radiation:**    Head \_\_\_    Neck \_\_\_    Shoulder \_\_\_    Arm \_\_\_    Hand \_\_\_    Buttock \_\_\_    Hip \_\_\_    Leg \_\_\_    Foot \_\_\_  
**Aggravated by:**    AM    PM    Sleeping    Bending    Twisting    Standing    Sitting    Lifting    Cough/Sneezing    Stress  
**Relieved by:**    AM    PM    Sleeping    Bending    Twisting    Standing    Sitting    Lifting    Cough/Sneezing    Stress  
**Date of Onset:** \_\_\_\_\_

**Third Complaint:** \_\_\_\_\_  
**Date of Onset:** \_\_\_\_\_ **Type of Onset:**    Sudden    Gradual    Traumatic    Chronic    Unknown  
**Type of Pain:**    Dull Ache    Sharp    Shooting    Stiffness    Numbness    Tingling    Weakness    Throbbing    Burning  
**Pain Frequency:**    Constant (76-100% of the day)    Frequent (51-75%)    Occasional (26-50% )    Intermittent (0-25%)  
**Pain Intensity:**    Minimal    Slight    Moderate    Severe                      Pain Rating (1-10): \_\_\_\_\_  
**Radiation:**    Head \_\_\_    Neck \_\_\_    Shoulder \_\_\_    Arm \_\_\_    Hand \_\_\_    Buttock \_\_\_    Hip \_\_\_    Leg \_\_\_    Foot \_\_\_  
**Aggravated by:**    AM    PM    Sleeping    Bending    Twisting    Standing    Sitting    Lifting    Cough/Sneezing    Stress  
**Relieved by:**    AM    PM    Sleeping    Bending    Twisting    Standing    Sitting    Lifting    Cough/Sneezing    Stress  
**Date of Onset:** \_\_\_\_\_

Additional Complaints: \_\_\_\_\_  
\_\_\_\_\_

**Past History of Condition (s)** \_\_\_\_\_  
**Doctors seen for this treatment:** \_\_\_\_\_ **Date of Last Visit:** \_\_\_\_\_  
**What treatment did you receive/ results?** \_\_\_\_\_  
**What test have you had for this condition?**    X-rays    MRI    CT Scan    Other: \_\_\_\_\_  
**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_