



Advanced Chiropractic of Virginia

**Consultation Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please fill out the following questions to the best of your ability, if they do not apply leave the question blank**

• Reason for your visit today (primary complaint): \_\_\_\_\_

• How long have you had this problem? \_\_\_\_\_

• How often does this problem bother you? \_\_\_\_\_

• Are there any other health problems / concerns you have that you may not have considered chiropractic care could help? For example, do you have any sinus problems, asthma, diabetes, digestive trouble, arthritis, fatigue, sleep problems or anything else (secondary complaint)? \_\_\_\_\_

• How long have you had this problem? \_\_\_\_\_

• How often does this problem bother you? \_\_\_\_\_

• At your examination today, do you mind if the doctor looks for damage related to your secondary complaint?      Yes      No

• Is there anyone else in your family who suffers from a similar condition to you or any of the conditions listed above?

Who	What Problem	Care he/she is receiving	Local?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please complete the following for both your primary and secondary complaint (if this applies to you)**

• Before you began to suffer from your primary and secondary complaints were there any accidents, injuries, or physical stress that may have caused harm to your spine or nervous system? (This includes your childhood to today. Examples: falls, auto accidents, work injuries, sports traumas, repetitive motion for work or sports, sitting at a computer or desk for long hours, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Since you began to suffer from your primary and secondary complaints, what, if anything, have you tried to do to help them that have not worked permanently? (Examples: Ice, heat, rest, over-the-counter medicines, prescriptions, P.T., etc.)
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- Did these give you temporary relief?      Yes      No
  - Do you see that these things have not truly fixed your problem?      Yes      No
  - Does this ever frustrate you?      Yes      No
  - If no, how would you say it makes you feel to have to deal with your primary and secondary complaints? \_\_\_\_\_
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- When these problems are at their worst, describe what happens: (Do you get nauseous, irritable, restricted in motion, have to lay down, etc.) \_\_\_\_\_
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**The following questions are about how your primary and secondary complaints affect your life so that we can better measure your progress and the benefits of your care here in the future**

- Do your health problems affect your job?      Yes      No
  - Are you less productive at your job because of your health problems?      Yes      No
  - Do you enjoy your job less because of your health problems?      Yes      No
  - Does your boss or co-workers notice a change in your performance?      Yes      No
  - When these problems are at their worst, does it affect your relationship with family and/or friends?      Yes      No
  - If yes, does this disappoint you or them more? \_\_\_\_\_
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- When these problems are at their worst, does it prevent you from doing things you enjoy such as hobbies or special interests?      Yes      No
  - Are there things that you would try, or do more of if it weren't for these problems?
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**Sleep is vital to a healthy immune system; please answer the following to the best of your ability**

- Do you have:
  1. Trouble falling asleep due to discomfort or pain?      Yes      No
  2. Restless sleep?      Yes      No
  3. Awakening in the middle of the night?      Yes      No
  4. Waking earlier than you should?      Yes      No

- If yes, does this have negative affects on your life?      Yes      No

**So that we have a better idea of how you see your care here progressing...**

- Do you agree that a different approach than what you have already tried is going to be necessary to get rid of your health problems completely?      Yes      No

- On a scale of 1 – 10 (ten being the most) how much so you want to get rid of your health problems completely? \_\_\_\_\_

- Assuming we can help you with your health problems, is there anything that may prevent you from following through with a wellness plan here at Advanced Chiropractic of Virginia?      Yes      No

Concerns are: (Examples: Time, transportation, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_