Physical Consultation Questionnaire

Name____

Date of Birth____

Phone____

Email____

Please complete to the best of your ability.

1. Please describe your condition in your own words. Please include all details no matter how random/insignificant they may seem. You can include extra pages if necessary.

2. Please list all medical diagnostic procedures you have had to help figure out your problem.

3. Have you had surgery for your problem? Y ( ) N ( )

4. Please list any surgeries you have had.

5. Please list all medications.

6. Please list any allergies.

7. Please describe any issues you have had or having with your bowel and/or bladder.

8. Please describe your emotional outlook.

9. Please describe your sleep patterns.

10. Please describe your nutritional habits.

11. Please describe your exercise routine.

12. Please list all interventions you have tried to help eliminate your condition. Please describe if you had relief with any of the interventions/modalities you have tried. Please describe if any of the interventions/modalities made you worse.

13. Please describe your past and present level of function. Please list the activities you can no longer perform.

14. What is your overall goal of this consultation?

15. Is there anything else I need to know?

Do you have or have you had any of the following?

Asthma, Bronchitis, Emphysema	___	Heart Attack/Surgery	___	Thyroid Disease	___
Shortness of breath, chest pain	___	Stroke/TIA	___	Anemia	___
Coronary Heart Disease	___	Congestive Heart Disease	___	Infectious Disease	___
Pacemaker	___	Blood Clot/Emboli	___	Diabetes	___
High Blood Pressure	___	Epilepsy/Seizure	___	Cancer	___
Arthritis	___	Sleeping Problems	___	Emotional/Psych	___
Headaches	___	Vision/Hearing Problems	___	Numb/Tingle	___
Dizzy/Faint	___	Weakness	___	Weight/Energy Loss	___
Hernia	___	Varicose Veins	___	Pins/Metal Implants	___
Joint Replacement	___	Pregnancies	___	Breast Implants	___

Client Signature

I, ____, have provided Christy Sanger with all of the information in as much detail as possible. I verify that all the information is true. I further understand that this consultation does not take the place of any consultations/treatment plan with any medical providers.

Client Signature____