Chiropractic Consultation Form

Everett Health Center, 115 East Ohio Ave, Sebring, OH 44672

Patient Information

- Full Name: _____
- Date of Birth: _____/_____/_____
- Phone Number (Cell): _____
- Email Address: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Emergency Contact Name: _____
- Preferred Method of Communication: ☐ Text ☐ Phone Call ☐ Email

Health Information

1. What brings you in today?

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2. When did the pain/symptoms start?

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3. Was there a specific incident that caused it? (e.g., auto accident, fall, sports injury)

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4. How would you describe the pain? (Check all that apply)
   ☐ Sharp ☐ Dull ☐ Burning ☐ Tingling ☐ Numbness ☐ Other: _____
5. Does the pain radiate to any other area of the body?
   ☐ Yes ☐ No
   If yes, where? _____
6. What makes the pain worse or better? (Check all that apply)
   - Worse with: ☐ Movement ☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ OTC Medications ☐ Other: _____
   - Better with: ☐ Movement ☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ OTC Medications ☐ Other: _____
7. Have you sought any other treatment (including chiropractic care) for this condition?
   ☐ Yes ☐ No
   If yes, what kind and what was the outcome? (continued on next page)

Consent for Chiropractic Consultation
I understand that this consultation is for discussing my condition and possible chiropractic care options. I acknowledge that this consultation is for informational purposes only and does not include a physical examination, diagnosis, or treatment.

I understand that if I choose to proceed with chiropractic care, a separate examination will be required, which may take place at a different time or date. At that time, the staff will explain the new patient process and financial policy.

We look forward to welcoming you to Everett Health Center and hope you become part of our chiropractic family.

I confirm that the information provided is accurate and complete to the best of my knowledge.

Signatures
Patient/Guardian Signature: _____ Date: //_____
Clinician Signature: _____ Date: //_____