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New Consultation Checklist

Patient Introduction

Your Name:

_____

First Middle Last

Your Address:

_____

Street City/State Zip

Phone:_____

Email: _____

Birth Date: _____

Marital Status: _____

Occupation: _____

Employer: _____

Current Physician: _____ City: _____

Referred By: _____

Thank You!

Red River Chiropractic & Wellness
250 25th St S - Fargo ND 58103
701-235-2700

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Initial Consultation

Name: _____ Date: _____

Main Complaints:

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1)_____ 2) _____

3)_____ 4) _____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

Would you like improvement with any of the following?

- ☐ Digestion: Reflux, Gas, Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy

What have you tried doing to resolve this problem that Did Not work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

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Hobbies: _____

Life: _____

When it's at its worst, how much older does this make you feel?

_____

Do you know how this problem may have started?

_____

_____

What effect does this have on your body functions?

_____

_____

Are you here visiting us to:

Resolve my immediate problem
Lifestyle program for optimized living
Both
Other: _____

How have you taken care of your health in the past? (Please circle)

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet and Nutrition	Other: _____

How did the previous methods work for you?

_____

_____

What are you afraid this might be or will be affecting without change? (Please circle)

Job	Kids	Marriage	Sleep
Freedom	Future abilities	Finances	Time

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Are there any health conditions you are afraid this might turn into? (Please circle)

Diminished future abilities	Surgery
Stress	Arthritis
Weight gain	Cancer
Heart disease	Diabetes
Depression	Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of?

(Please be specific)

_____

_____

_____

What would be different or better without this problem? (Please circle)

Diminished stress	Sleep
More energy	Work
Self-esteem	Outlook
Confidence	Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

_____

_____

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Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy a mentor in helping you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!