the DMR method

Initial Consultation

Date: _____

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ PO Box_____ City _____

State _____ Zip _____ Birth date _____/_____/_____ Age _____

Home phone _____ Cell phone _____ Work phone _____

Email address _____ SS # _____ Sex [ ] Male [ ] Female

[ ] Married [ ] Single [ ] Minor [ ] Widowed [ ] Divorced [ ] Separated [ ] Partnered

Spouse's Name _____ Whom may we thank for referring you? _____

Patient's Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

In Case of Emergency, Contact:

Name _____ Relationship _____

Home phone _____ Cell phone _____ Work phone _____

Accident/Injury Information

Is your condition due to a recent accident or injury (within the last year)? [ ] No [ ] Yes, **Date** _____

Type of accident: [ ] Auto [ ] Home [ ] Work [ ] Other _____

Brief description _____

To whom have you made a report of your accident? [ ] Auto insurance [ ] Employer [ ] Worker Comp.

[ ] Other _____ Attorney Name (if applicable) _____Phone _____

Current Health Concerns

List your health care concerns: _____

_____

When did your symptoms appear? _____

Is this condition getting progressively worse? [ ] Yes [ ] No [ ] Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Shooting

[ ] Burning [ ] Tingling [ ] Cramps [ ] Stiffness [ ] Swelling

[ ] Other _____

How often do you have this pain? _____

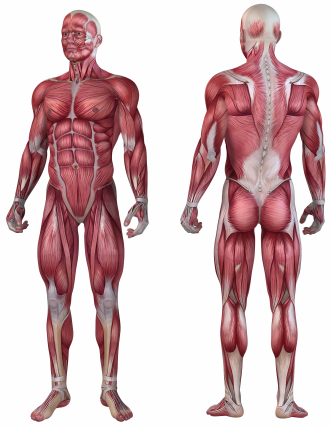
Is it constant or does it come and go? _____

Does it interfere with your [ ] Work [ ] Sleep [ ] Daily routine [ ] Recreation

Activities or movements that are painful to perform: [ ] Sitting [ ] Standing [ ] Walking

[ ] Bending [ ] Lying down [ ] Lifting [ ] Other_____

Please mark on the diagram where you have symptoms



Are you currently receiving treatment for any healthcare conditions? [ ] Medications [ ] Surgery [ ] Physical Therapy

[ ] Chiropractic [ ] None [ ] Other _____

Name and location of other doctor(s) who have treated you for your condition

_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ Urine Test _____

Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Are you pregnant? [ ] Yes [ ] No Due Date _____

Health History

Place a mark to indicate if you have had any of the following:

[ ] AIDS/HIV	[ ] Chicken Pox	[ ] Liver Disease	[ ] Rheumatoid Arthritis
[ ] Alcoholism	[ ] Diabetes	[ ] Measles	[ ] Rheumatic Fever
[ ] Allergy Shots	[ ] Emphysema	[ ] Migraines	[ ] Scarlet Fever
[ ] Anemia	[ ] Epilepsy	[ ] Miscarriage	[ ] Stroke
[ ] Anorexia	[ ] Fractures	[ ] Mononucleosis	[ ] Suicide Attempt
[ ] Appendicitis	[ ] Glaucoma	[ ] Multiple Sclerosis	[ ] Thyroid Problem
[ ] Arthritis	[ ] Goiter	[ ] Mumps	[ ] Tonsillitis
[ ] Asthma	[ ] Gout	[ ] Osteoporosis	[ ] Tuberculosis
[ ] Bleeding Disorders	[ ] Heart Disease	[ ] Pacemaker	[ ] Tumor, Growth
[ ] Breast Lump	[ ] Hepatitis	[ ] Parkinson's Disease	[ ] Typhoid Fever
[ ] Bronchitis	[ ] Hernia	[ ] Pinched Nerve	[ ] Ulcers
[ ] Bulimia	[ ] Herniated Disc	[ ] Pneumonia	[ ] Venereal Disease
[ ] Cancer	[ ] Herpes	[ ] Polio	[ ] Whooping Cough
[ ] Cataracts	[ ] High Blood Pressure	[ ] Prostate Problem	
[ ] Chemical Dependency	[ ] High Cholesterol	[ ] Prosthesis	
	[ ] Kidney Disease	[ ] Psychiatric Care	

[ ] Other _____

Exercise	Work Activity	Habits	
[ ] None	[ ] Sitting	[ ] Smoking	Packs/day _____
[ ] Moderate	[ ] Standing	[ ] Alcohol	Drinks/week _____
[ ] Daily	[ ] Light Labor	[ ] Coffee/Caffeine	Cups/day _____
[ ] Heavy	[ ] Heavy Labor	[ ] High Stress Level	Cause _____

Injuries/Surgeries you have had

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name _____

Pharmacy Phone _____

Notes: