Consultation Form

Prospective Patients Name: ____

Date: ________________ Time : ____________________Phone# _____________

Weight ______________ Age ____________________ Height________________

Describe the symptoms you are experiencing? _____________________________

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Have you been clinically diagnosed? _____________________________________

How long have you had ____________________________ (headaches, pain, etc.)

How does it affect you at work? _______________________________________
At home? ____

How have you tried to get rid of the problem? ____________________________

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Are you on any medications? ____

For How Long? ____

We are in agreeance to conduct an advisory consultation between two responsible adults in pursuit to find information that maybe provide help in the recovery of the human body.