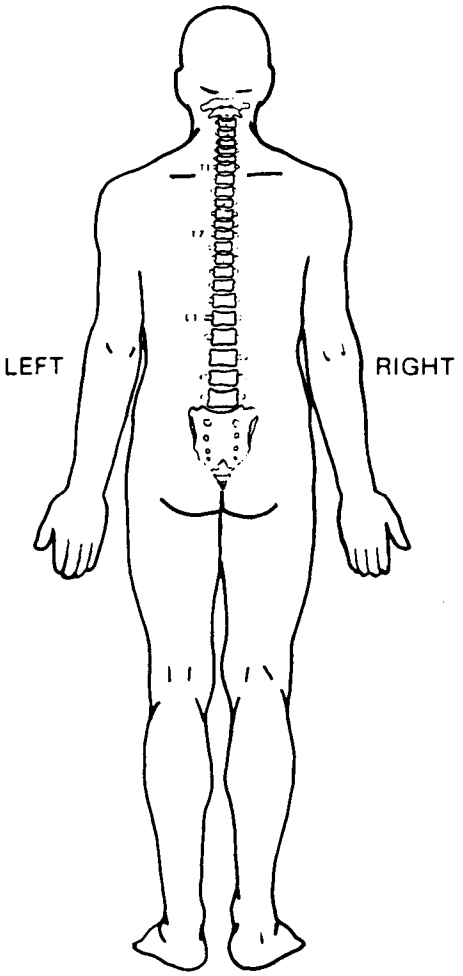
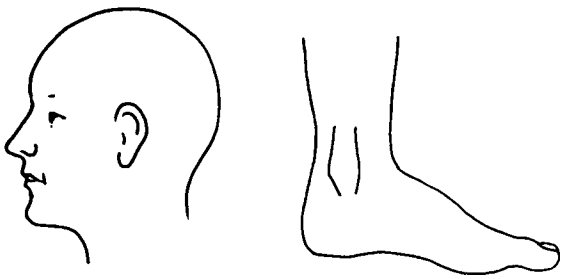
# PATIENT CONSULTATION

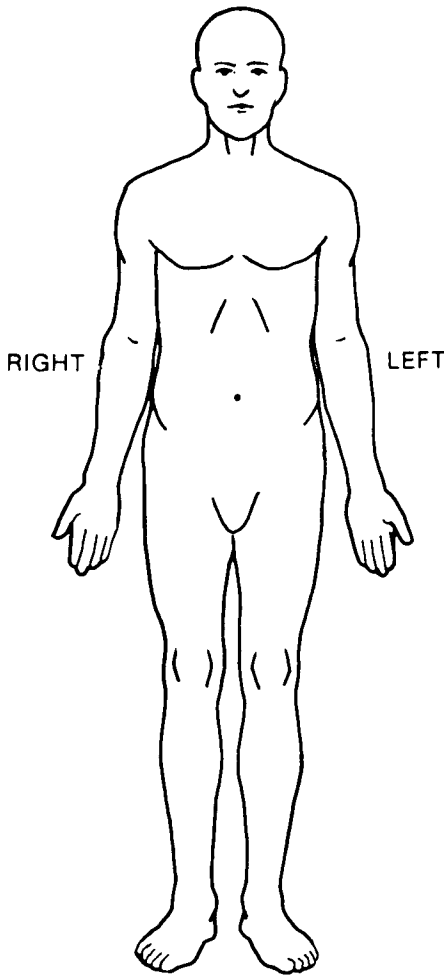
NAME: _____ Date: _____ By: _____

P.O.P. _____

_____






## Major Complaints

1. _____
2. _____
3. _____
4. _____
5. _____

N - Numbness P - Pain T - Tingling A - Ache S - Soreness ST - Stiffness

Organic Symptoms: _____

_____

_____

D.O.C.: _____

N.L.W.: _____

_____

A.E.P.: _____

H.P.: _____

P.S. (F.A.): _____

N.O.D.: _____

P.D.: _____

F.T.: _____

_____

L.O.T.: _____

_____

Other: _____

_____

POP - Position Of Pain • DOC - Duration Of Condition • NLW - Normal Living & Working • AEP - Adverse Environmental Possibilities • HP - Heriditary Possibilities
PSFA - Previous Surgery, Falls & Accidents • NOD - Names Of Doctors • PD - Previous Diagnosis • FT - Former Treatment • LOT - Length Of Treatment

(Other side can be used for additional and miscellaneous notes.)



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