Dr. Donald D'Lusky
Orthopedics • Chiropractic • Nutritionist
304-367-1000 • drdlusky.com • 307 Tenth Avenue • Fairmont, WV 26554

Consultation Questions

Name____ Date_____________________

1. How long has this been bothering you? ____
2. Have you had this or similar problems in the past? Yes No
3. What have you done for this in the past? MD DC OD PT DRUGS
4. Did you find this effective? Yes No
5. What have you tried for it this time? ICE HEAT OTC OTHER
6. Have you for that effective? Yes No
7. Are you allergic to anything? Yes ________________________ No
8. Has anyone else in your family experienced this or a similar problem? Yes No
   (if yes who?)____
9. Does this interfere with normal living or working? Yes No
10. Have you seen another Dr. for this problem? Yes No
    (if yes who?)______________________________________
11. What did he/she recommend? ____
12. Did you find this effective? Yes No
13. Have you seen any other Dr. for any other problems recently? Yes No
    (if yes who?)________________________
14. Has anyone recommended surgery? Yes No ____
15. Have you noticed changes in your elimination habits or problems with hemorrhoids yet? Yes No
16. Have you noticed any hot/cold spots up and down your arms? Yes No Frequent Infrequent
17. Do your arms and legs ever become painful? Yes No Frequent Infrequent
18. Have you noticed and numbness in your arms/legs? Yes No
19. What position increases your pain__________________________ decreases your
    pain________________________.
20. Have you had any serious circulatory problems? Yes No

21. Any painful varicose vein conditions? Yes No
22. Have you noticed any weakness in your arms or legs? Yes No Frequent Infrequent
23. Any loss of sex drive? Yes No
24. Any pain before, during, or after intercourse? Yes No
25. Does it seem possible there is some connection between your accident and what you're experiencing today? Yes No
26. Does it seem possible that there is a connection between your primary symptoms of ________________________ and your correlating symptoms of ________________________________?
27. Have you had prior chiropractic adjustments? Yes No

Name____ Date_____________________________________

Primary Problem

What are your problems?_____________________________
How did the problems occur?__________________________
Date it occurred?____________________________________
Have you had this pain before?_______________________

How do you feel when doing the following:	Hurts	Helps	No Change
urinate/move bowels			
cough/sneeze			
Early morning			
Middle of night			
Evening			
Sitting			
Lying down			
Driving			
Bending			
Standing			
Walking			
Change of position			

Secondary Problem

What are your problems?_____________________________
How did the problems occur?__________________________
Date it occurred?____________________________________
Have you had this pain before?_______________________

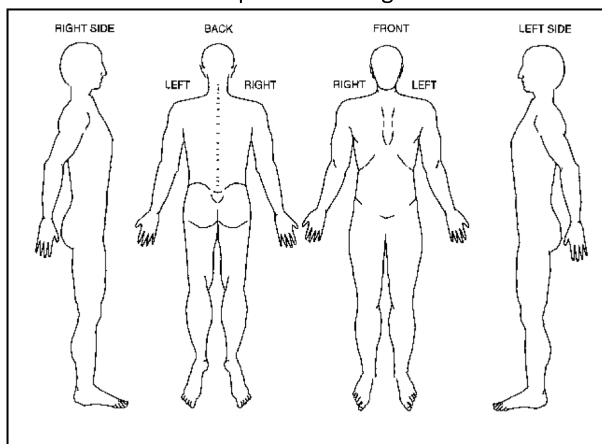
How do you feel when doing the following:	Hurts	Helps	No Change
urinate/move bowels			
cough/sneeze			
Early morning			
Middle of night			
Evening			
Sitting			
Lying down			
Driving			
Bending			
Standing			
Walking			
Change of position			

Implants/ Transplants?

Pain Scale (grade your pain) 1 2 3 4 5

Pain Scale (grade your pain) 1 2 3 4 5

Please mark areas of pain on the figures below



KEY:
Stabbing ///
Burning XXX
Numbness ===
Other >>>

Do you have headaches? Yes No
Location:____________________________
Frequency:___________________________
Ringing in ears? Yes No
Advanced warnings? Yes No
Nausea? Yes No
Pain Scale: 1 2 3 4 5

Work: (please describe the type of work you do)

____

List all leisure activities:

____