Moving Into Harmony
discover ~ integrate ~ evolve

INITIAL CONSULTATION FORM: To best assist you, and evaluate your condition fully, please fill out to the best of your ability and as accurate as possible. Thank you.

CLIENT'S NAME:_____ AGE:_____

OCCUPATION(if retired, from what?):_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1	Briefly explain what is troubling you and how it is affecting your daily life function.		
2.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do		
3.	Where is your pain/condition?		
4.	What do you feel caused your pain/ challenge?		
5.	Approximately when did it start?		
6.	Have you ever had this same (or similar) pain/condition before?	❑ Yes (If yes, when and describe?) ❑ No	
7.	In your understanding, what do you feel will make the pain/condition not be limiting?		
8.	How optimistic are you that you'll get better? (circle one)	Not at all.....Mildly optimistic.....Fairly.....Very optimistic.....Extremely	
9.	What are some potential obstacles to you getting better?		
10	What are your stressors in your life?		
11	What are your main sources of support?		
12.	Over the next 60-days, how many hours per week will you commit to improving		
13.	What are you expecting from therapeutic interventions?		
14.	On the scale, circle your worst pain level in the past couple of weeks:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
15.	List any medications you are taking:		
16.	List all past surgeries with dates:		
17.	List the medical conditions you have, or feel might be related to your pain/ condition (or were told you have):		

I understand that my options for care and my successful outcome are dependent upon my ability and willingness to participate in my therapeutic solutions; which includes an active role in learning, practicing and integrating ways and actions that promote recovery and reaching my goals and desired outcomes. I understand that I have a role in developing a self-care program, and devoting the time needed to achieve my goals and desired outcomes. I have answered the questions above honestly and accurately to the best of my ability. I understand the therapist will determine the best plan of care from my answers and stated goals, and discuss the results of finding in the evaluation process, and plan of care options.

Patient Signature (or guardian):_____ Date: _____