



PRACTICE MEMBER INITIAL QUESTIONNAIRE

Name: _____

Date: _____

I. Chief Physical Complaints (in order of priority) rate from 1-10 with 10 being worse

1. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

2. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

3. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

4. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

5. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

II. Chief Emotional Complaints

1. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

2. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

3. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

4. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

5. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

III. Any other concerns that you would like the doctor to know about?

IV. What would you like to accomplish from this healing process?

1.

2.

3.

4.

5.
