Doral Spine & Wellness Center

8726 NW 26th Street Ste 16
Doral, Florida 33172
305.477.7976

Date: ________________
Day:_________________
Time:________________

Pre-Consultation Checklist

__ Complete paperwork prior to coming to appointment.

__ If you have any labs from the past 6 months, bring those as well.

__ Spouse/Significant Other required to attend your consultation.

__ Arrive promptly for your scheduled appointment so that you may have as much time with Dr. Carril as possible.

We require at least 24 hour notice if your scheduled appointment time needs to be changed or canceled. No refund will be given for this appointment.

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Patient Introduction

Personal History:

Name: ____
First Middle Last

Address: ____
Street City/State Zip

Telephone: Home:______________________________ Bus:___________________________________

Email Address:____

Insurance Carrier:____

Birth date: ___________________

Social Security: ___________________

Marital Status: ___________________

Occupation: ___________________

Employer: ___________________

Present MD:____ City: ____________________________

Referred to our Center by: ____

Doral Spine & Wellness Center

Initial Consultation

Name:____ Date:__________________________

Main Complaints:

1)____________________________________ 2)____________________________________

3)____________________________________ 4)____________________________________

How long have you suffered with each of these problems?

1)____________________________________ 2)____________________________________

3)____________________________________ 4)____________________________________

Any other complaints?____
____.

Medications:

1)____________________________________ Condition:________________________________

2)____________________________________ Condition:________________________________

3)____________________________________ Condition:________________________________

4)____________________________________ Condition:________________________________

5)____________________________________ Condition:________________________________

6)____________________________________ Condition:________________________________

Thyroid Patients Only:

1) How long did you have symptoms prior to being diagnosed?_________________________
2) If any thyroid medication, how long have you been on it?____________________________
3) Has your medication been adjusted frequently?___________________________________
4) Do you have symptoms of brain fog or memory difficulties?_________________________
5) Do you have joint inflammation?____
6) Do you consume grains? Y / N Do these irritate your bowels? Y / N
7) Heart palpitations? Y / N
8) Hot flashes or sweat attacks? Y / N
9) Have you been diagnosed with autoimmune condition?______________________________

Would you like improvement with any of the following?

[ ] Digestion: Reflux, Gas, Constipation
[ ] Sleep: Falling asleep or staying asleep
[ ] Sense of Well Being
[ ] Energy

What have you tried doing to resolve this problem that did not work?____________________________

____.

Have you become discouraged or stressed about handling this problem?__________________________

____.

When your problem is at its worst, how does it make you feel?__________________________________

____.

How does this problem interfere with the following areas in your life?

Work:____
Family:____
Hobbies:____
Life:____

How much older does this make you feel?____

Do you know how this problem may have started?____

____.

What effect does this have on your body functions?_______________________________________

____.

Are you here visiting us to?

A) Resolve my immediate problem
B) Life style program for optimized living
C) Both
D) Other:____

How have you taken care of your health in the past?

Medications
Routine Medical
Exercise
Diet/Nutrition
Holistic
Vitamins
Chiropractor
Other:_____________________________

How did the previous methods work for you?____.

What are you afraid this might be or will be effecting without change? Please Circle

Job	Freedom
Kids	Future Abilities
Marriage	Finances
Sleep	Time

Are there any health conditions you are afraid this might turn into?

Thyroid Dysfunction	Surgery
Stress	Arthritis
Weight Gain	Cancer
Heart Disease	Diabetes
Depression	Other:____________________________

Where do you picture yourself being in the next 3 – 5 years if this problem is not taken care of? Please be specific.____

What would be different or better without this problem? Please Circle:

Diminished Stress	Sleep
More Energy	Work
Self Esteem	Outlook
Confidence	Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short!!! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

____

What potential barriers do you foresee that would prevent these things from happening?__________
____
____
____

Do you feel it is possible to eliminate or prevent these potential barriers?_______________________
____.
____.
____.

What are your strengths that will enable you to accomplish your goals? ________________________
____.
____.
____.

Rate on a scale of 1 to 10:

__________ How important is it for you to resolve your health concerns?
__________ How coach-able do you feel and would enjoy a mentor in helping you?
__________ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!