Welcome to Crist Chiropractic

Please Print Clearly and Fill In Completely.

Print Name _____ **Email**_____

Street Address _____ **City** _____ **State** _____

Zip Code _____ **Phone(s) Home:** _____ **Work/Cell**_____

Date Of Birth _____ **Social Security Number** _____

Please Check ✓ **Sex: Male☐ Female☐** **Married☐ Single☐**

Health History:

Please list your chief complaints: 1)_____For how long?_____
(In order of severity) 2)_____For how long? _____
3)_____For how long? _____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes☐ No☐

If Yes, please list the conditions being treated: _____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents and dates: _____

Personal & Family History:

Your Employer: _____ Your Occupation:_____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Health Status: _____

Children's Ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes☐ No☐ If Yes, Doctor's Name:_____

Date of last chiropractic visit: _____ What was your reason for care? _____

Date of last Chiropractic x-rays: _____ How long were you under care? _____

Are other family members under chiropractic care? Yes☐ No☐ Who? _____

Where did you hear about our clinic, or who referred you? _____

FEMALES: ***Please Check one*** ✓ Is there a possibility of you being pregnant? Yes☐ No☐

Insurance/Billing Information: *Please check one* ✓

No Insurance ☐ Major Medical Health Insurance ☐ Name of Ins. Co.: _____

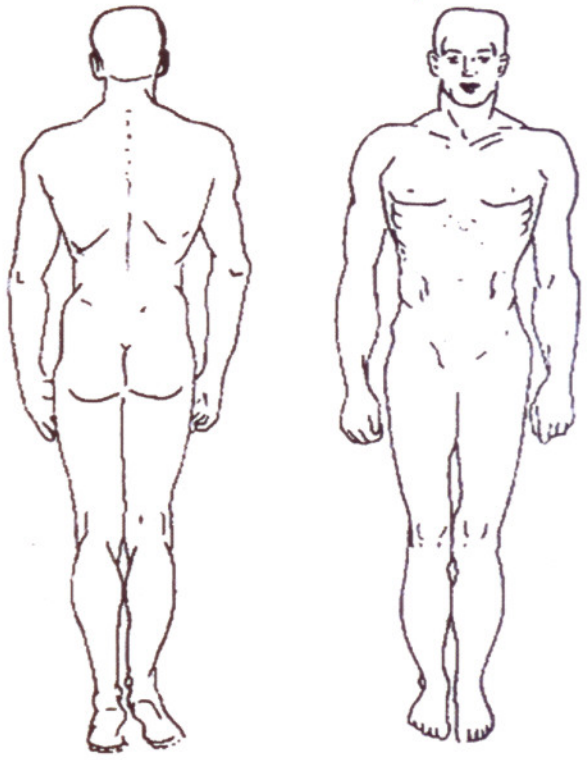
Is this the result of an *auto* or *work injury*? Yes☐ No☐ If Yes, when? _____

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Vision Changes	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Frequent colds	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____