Welcome to Crist Chiropractic

Today's Date________________

Name____**DOB**___/___/___**Age**______ **Male/Female**

Address______________________________________**City**_________________**State**_____**Zip**__________

Phone: Home___________________ **Cell**__________________ **Cell Phone Provider**________________

Email Address____

Occupation__________________________________ **Employer's Name** ____________________________

Single / Married / Divorced / Widowed **Spouse's Name**__________________________________

Number of Children______ **Names, Ages & Gender**____

____

Who may we thank for referring you? ____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. ____________	____________	____________	____________	____________	____________
2. ____________	____________	____________	____________	____________	____________
3. ____________	____________	____________	____________	____________	____________
4. ____________	____________	____________	____________	____________	____________
5. ____________	____________	____________	____________	____________	____________

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? __________________________ MEDICAL DOCTOR? ________________________________

OTHER ___________________________________ WHO AND WHEN? __________________________________

WOMEN ONLY: ARE YOU PREGNANT? ____________

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*GASTRIC REFLUX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER*___________
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	_______________
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*	*RHEUMATOID A.*	_______________
CHRONIC SINUS	*BLADDER PROBLEMS*	*KNEE PAIN*	*OSTEOPOROSIS*	_______________

PATIENT'S NAME: ______________________________ DATE: ____________________

CIRCLE *ANY CONDITION YOU HAVE NOW/ HAVE HAD:*

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

EXPLAIN:____

____

LIST ALL SURGICAL OPERATIONS AND YEARS______________________________

____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

____

____

____

IS CONDITION DUE TO AN ACCIDENT? YES / NO

WHEN WAS YOUR LAST AUTO ACCIDENT______________________________

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE______________________________

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE______________________________

OTHER TRAUMA:______________________________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull **S** = Stabbing/Cutting
B = Burning **T** = Tingling (Pins & Needles)
N = Numb **C** = Cramping