

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

