Christensen Chiropractic Clinic, P.C. Patient History

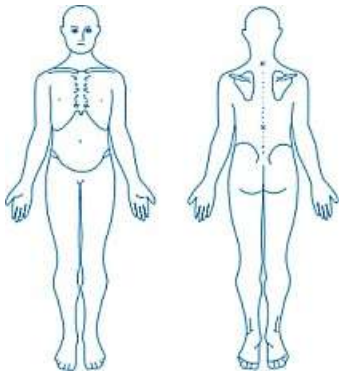
Name: _____ **DOB:** ___/___/_____

List the problems you would like us to address:

1:_____
2:_____
3:_____
4:_____

When did these problems start? _____
Did you have an accident? ☐yes ☐no.
If yes, what happened? _____
If you are having pain, describe it i.e. aching, sharp, tingling_____
How would you rate the pain on a scale from 1-10 if 10 is the worst _____
Does the pain radiate? _____ Where? _____
What makes the problem worse? _____
What makes the problem better? _____
Does it interfere with your activities or sleep? ☐yes ☐no. Which?_____
Have you seen any other doctors or had any other treatment? ☐yes ☐no.
If yes, who did you see and what was done or recommended? _____
_____
Have you had x-rays, MRI, cat scans or lab work? _____ Where? _____
Have you seen a Chiropractor before? ☐yes ☐no. _____
Who is your medical provider? _____.

Mark on the picture where you feel your problem:



Notes:
_____
_____
_____
_____
_____
_____

Do you drink caffeine or alcohol? ☐yes ☐no.
Do you exercise? ☐yes ☐no.
List any surgeries you have had: _____
Please list any previous injuries: _____

Mark any of the following conditions you have had:

☐AIDS/HIV	☐Diabetes	☐High Cholesterol	☐Polio	☐Varicose Veins
☐Anemia	☐Emphysema	☐Jaw Pain/ TMJ	☐Prosthesis	☐West Nile
☐Anorexia	☐Epilepsy	☐Kidney Disease	☐Psychiatric Care	☐Whiplash
☐Appendicitis	☐Glaucoma	☐Liver Disease	☐Rheumatoid	☐Other_____
☐Arthritis	☐Gout	☐Mononucleosis	☐Rheumatic Fever	
☐Asthma	☐Heart Disease	☐Multiple Sclerosis	☐Scarlet Fever	
☐Blood Clots	☐Hepatitis	☐Osteoporosis	☐Stroke	
☐Breast Lump	☐Hernia	☐Pacemaker	☐Thyroid Problems	
☐Bronchitis	☐Herniated Disc	☐Parkinson's	☐Tuberculosis	
☐Cancer	☐Herpes	☐Pinched Nerve	☐Tumors/Growths	
☐Cataracts	☐Hypertension	☐Pneumonia	☐Ulcers	