Chris Family Chiropractic History Form

Name_____ Date_____
Address_____ Date of Birth_____
City_____ State_____ Zip_____ Social security_____
Home Phone_____ Cell Phone_____ E-mail_____
Occupation _____ Employer's Name _____Work Phone_____
Gender M F Single Married Divorced Widowed Spouse's Name_____
Whom may we thank for referring you to our office? _____

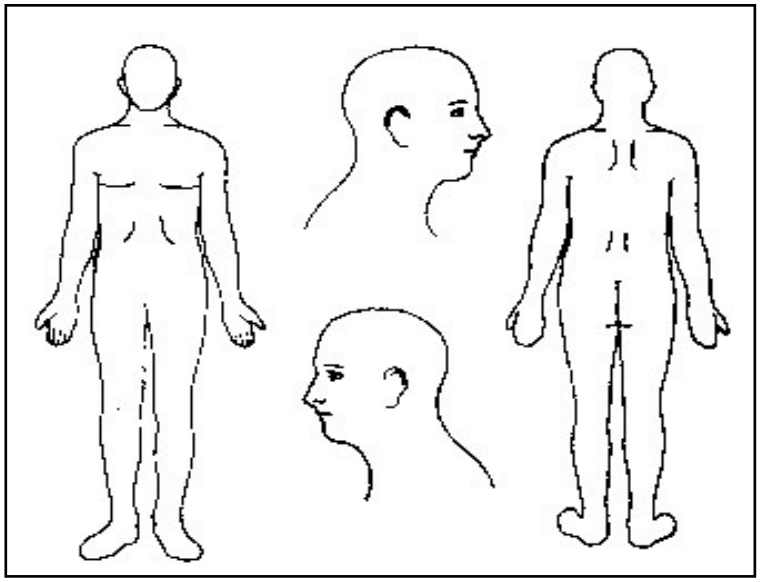
Main Problem

What symptom causes you to come to the office? _____
What caused this symptom? _____
When did this pain start? _____ Has it been getting better, worse or staying the same? _____
How bad is this symptom? (Circle the one that applies) Mild, Moderate, Severe, Intolerable
Circle the word or words that best describe your symptom. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening-like, Throbbing, Nagging, Burning, Deep, Stinging, Pressure-like
How often does the symptom occur? (Circle the one that applies) Occasional, Frequent, Constant
Does this symptom travel to any other area? _____
What makes this symptom better? _____
What makes this symptom worse? _____
What else have you done to treat this symptom? _____
Did it help?_____

Other Problem

What other symptom do you have? _____
What caused this symptom? _____
When did this pain start? _____ Has it been getting better, worse or staying the same? _____
How bad is this symptom? (Circle the one that applies) Mild, Moderate, Severe, Intolerable
Circle the word or words that best describe the symptom. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening-like, Throbbing, Nagging, Burning, Deep, Stinging, Pressure-like
How often does the symptom occur? (Circle the one that applies) Occasional, Frequent, Constant
Does this symptom travel to any other area? _____
What makes this symptom better? _____
What makes this symptom worse? _____
What else have you done to treat this symptom? _____
Did it help?_____

Have you ever been to a chiropractor or medical provider for these conditions? **YES** **NO** When?_____
Provider name and address: _____
What was the outcome? _____



Put an "X" on the drawing on the areas causing your pain, and a letter describing it.

A = ache
B = burning
S = stabbing
N = numbness
P = pins and needles

INJURIES/SURGERIES YOU HAVE HAD:

Description of incident Date of incident

Falls_____
Head Injuries_____
Broken bones_____
Dislocations_____
Surgeries_____
_____
Car Accidents _____
_____

Please check all symptoms that are a concern to you.

✕ = currently have O = have had at some point in your past ⊗ = comes and goes F = family history

NECK-RELATED
___ Headaches
___ Pins and needles in arms
___ Dizziness/fainting
___ Loss of taste
___ Cold hands
___ Neck stiffness
___ Sinus/allergies
___ Heart pain
___ Neck pain
___ Numbness in fingers
___ Loss of smell
___ Buzzing/ringing in ears
___ Vision/eyesight problems
___ Facial pain or numbness

MID-BACK RELATED
___ Asthma
___ Mid-back pain
___ Heartburn
___ Stomach upset
___ Ulcers
___ High blood pressure
___ Heart problems
___ Eczema
___ Irritable bowel syndrome
___ Hepatitis
___ Lung/respiratory disease
___ Kidney disease
___ Difficulty deep breathing
___ Poor hearing

LOW-BACK RELATED
___ Menstrual pain
___ Menstrual irregularity
___ Pins and needles in legs
___ Low-back pain
___ Numbness in toes
___ Diarrhea
___ Urination problems
___ Cold feet
___ Constipation
___ Sterility/Infertility
___ Appendicitis
___ Gallbladder disease

GENERAL SPINE-RELATED
___ Irritability
___ Mood swings
___ Cold sweats
___ Loss of balance
___ Arthritis
___ Fatigue
___ Hot flashes
___ Sleeping problems
___ Depression
___ Nervousness

List any other conditions you have:_____

Circle if you currently have any of the following: Osteoporosis, benign bone tumors of the spine, bleeding disorders and anticoagulant therapy, radiculopathy with progressive neurological signs, acute rheumatoid arthritis, ankylosing spondylitis, acute or healed and unstable fracture/dislocation, unstable os odontoideum, spinal column malignancy, spinal column infection of the bones or joints, myelopathy or cauda equina syndrome, vertebrobasilar insufficiency syndrome, major artery aneurysm

List any medications you have taken in the last 3 months: (prescription, over-the-counter, vitamins, herbs) ____
_____
_____

For Office Use Only

Problem:_____

O:_____

P:_____

Q:_____

R:_____

S:_____

T:_____

The statements made on this form are accurate to the best of my recollection and I agree to allow Dr. Christopher E. Cyrul, D.C. to examine me for further evaluation:

Patient Signature_____ Date _____ Pt ID# _____

Provider Signature _____ Date _____