CHRISTIANSON
CHIROPRACTIC, PLLC

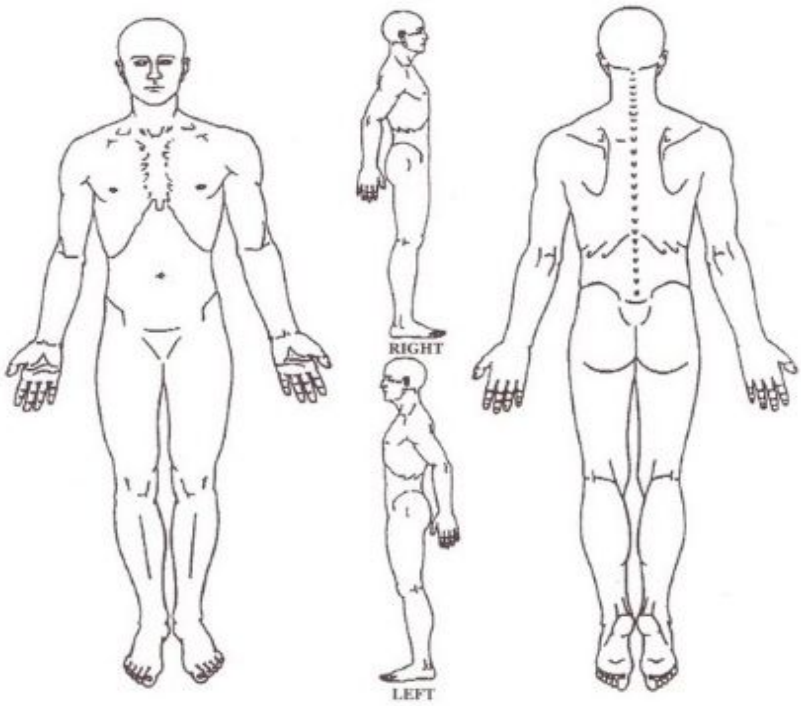
Christianson Chiropractic, PLLC
New Patient Case History

Name: _____ Date: _____

Major Complaint Information

Using the symbols provided in the Pain Index Box below, mark the areas on the illustrations to the right where you are experiencing symptoms, followed by a number from 0 to 10 indicating the extent of the pain. (0 being no pain, 10 being severe)

Pain Index	
D	DULL ACHE
B	BURNING
S	SHARP
N	NUMBNESS/TINGLING



What is/are your major complaint(s)? _____
_____
When did this symptom(s) begin? _____
If this is an injury, describe what happened? _____
Have you experienced these symptoms before? __Y __ N When? _____
What makes this condition worse? _____
What relieves the symptoms/ pain? _____
Have you seen another doctor for this condition? __Y __N Doctor's Name: _____
Date Consulted: _____ Diagnosis: _____
Does this condition interfere with your sleep? __Y __N If so, how many times do you wake up in pain per night?_____
In what position do you sleep? __Back __ Right Side __ Left Side __ Stomach
Do you sleep with a pillow? __Y __N How many?_____
Does heat affect the pain? __Y __N If so, how? _____
Does cold affect the pain? __Y __N If so, how? _____
Does it cause pain to cough, grunt, or sneeze? __Y __N If so, where? _____
Have you been x-rayed in the past 12 months? __Y __N When? _____
Have you ever been seen by a chiropractor before? __Y __N Please list:
Name of Chiropractor: Date: Name of chiropractor: Date:
_____ _____ _____ _____

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FILL OUT THE NEXT FIVE SECTIONS AS THEY APPLY TO YOU:

Lower Back Pain

Does pain radiate into your leg(s)? __Y __N Where? _____Does pain radiate to the abdomen? __Y __N

Has this pain caused an impairment of bowel or urinary function? __Y __N Explain: _____

Do you have numbness or tingling into the legs? __Y __N Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) __ Hearing ___ Vision ___Balance ___ Cause ringing in ears?

Do you hear grating sounds? ___Y ___N Do you feel pressure or pain behind your eyes? ___Y ___N

Does pain radiate into the arm(s)? __Y __N Where: _____

Do you have difficulty lifting or turning your head? Y N If so, in which direction? Right Left Up Down

Headaches

Do you get headaches? __Y __N Frequency_____ Do you have a family history of headaches? __Y __N

Do you experience the following along with your headaches: Pain or cracking in your jaw? __Y__N

Abnormal blood pressure? __Y __N __High __Low Nausea, Vomiting, or Visual Disturbances? __Y __N

When was your last eye exam by a doctor? __ 1-6 months __ 6-12 months __ 1-2 years __ over 2 years Results: _____

Check those activities below during which you experience difficulty of pain

__ Lying on back __ Getting in/out of car		__ Pulling	__Sitting	__Standing for long periods
__ Lying on side	__ Dressing self	__ Reaching	__ Bending Forward	__ Sneezing
__ Turning over in bed	__ Sexual Activity	__ Kneeling	__ Bending Backward	__ Coughing
__ Lying flat on stomach	__ Pushing	__ Stooping	__ Walking	__ Other: _____

Additional Complaints

__ Loss of concentration	__ Neck Stiffness	__Shortness of breath	__ Cold Hands	__Arthritis
__ Eyes Sensitive to Light	__ Neck Motion Restricted	__ Irritable	__ Cold Feet	__ HIV/AIDS
__ Memory Loss	__ Mid Back Pain/Stiffness	__ Depression	__ Hypertension	__ Other (Please List)
__ Heavy Feeling of Head	__ Lower Back Pain/Stiffness	__ Insomnia	__ Diabetes	_____
__Dizziness	__ Right/Left Shoulder Pain	__ Anxiety	__ Jaw Pain	_____
__ Ringing in Ears	__Right/Left Arm Pain	__ Fatigue	__Convulsions	_____

__ Loss of Balance __ Pins & Needles Arm/Legs __ Excessive Perspiration __ Allergies (Please list) Please Specify Location:

__ Loss of Smell	__Right/Left Leg Pain	__ Digestive Trouble	_____	__Numbness:_____
__Loss of Taste	___Vision Problems	__ Nausea	_____	__Swelling: _____
__Pain Behind Eyes	__ Sinus Trouble	__ Vomiting	_____	__Cuts: _____
__ Fainting	__ Nervousness	__ Diarrhea	__ Anemia	__ Bruising: _____
__ Heart Palpitations	__ Chest Pain	__ Constipation	__ Heart Disease	