# Craig Abrams, D.C.

4424 Jasmine Ave
Culver City, CA 90232


## Personal History Form

Patient: _____ Social Security Number: _____ - _____ - _____
Last, First

Home:
Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Mobile phone: _____ Email: _____

Gender: [ ] Male [ ] Female Birthdate: _____ Age:_____

Employer: _____ Occupation: _____

Work:
Address: _____ City: _____ State: _____ Zip: _____

In case of emergency contact: _____ Phone:_____

Referred by: _____

Have you ever been treated by a chiropractor before? [ ] Yes [ ] No

---

How would you describe your chief complaint at this time?

_____

_____

When did it start? _____
(Include date if known)

What makes the pain worse?_____

What makes the pain better? _____

How would you describe you pain? _____

At what time of the day or week is your pain worse? _____

The pain is: [ ] Intermittent [ ] Constant

Have you had this problem in the past? _____ If so, how often? _____

---

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise your heart rate? _____

When you engage in the activity noted above, what is the average duration of this activity?

[ ] 10 minutes or less [ ] 10-20 minutes [ ] 20-30 minutes [ ] 30-60 minutes [ ] over 60 minutes

When you engage in the physical activity above, what do you feel the effort is? _____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and rapid heart rate? _____

Craig Abrams, D.C.

4424 Jasmine Ave
Culver City, CA 90232

## Personal History Form – part 2

Please rate your level of fitness _____
(0 = very poor; 5 = average; 10 = excellent)

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

What Medications, vitamins, supplements, and herbs do you take?

| Name | Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Please list any allergies that you have:

_____

_____

_____

# Craig Abrams, D.C.

4424 Jasmine Ave
Culver City, CA 90232


## Comprehensive Medical History

Patient: _____ DOB: _____ Date_____
Last, First MM/DD/YYYY MM/DD/YYYY

Do you have a General Practitioner? [ ] Yes [ ] No

Would you like Dr. Abrams to act as your primary care physician? [ ] Yes [ ] No Date of last physical examination: _____

Instructions for Past Medical-Systems Review: Please check if you NOW or EVER have experienced the following:

CONSTITUTIONAL

1. [ ] Cancer
2. [ ] Allergies
3. [ ] Fever or chills
4. [ ] Weight loss or gain
5. [ ] Night sweats
6. [ ] Fatigue
7. [ ] Insomnia or changes in sleep
8. [ ] Other

ENDOCRINE

9. [ ] Diabetes
10. [ ] Thyroid disease
11. [ ] Intolerance to heat or cold
12. [ ] Increased thirst
13. [ ] Other

EYE, EAR, NOSE, THROAT

14. [ ] Glaucoma
15. [ ] Sinusitis
16. [ ] Poor vision
17. [ ] Pain in the eye
18. [ ] Deafness/Difficulty hearing
19. [ ] Nosebleeds
20. [ ] Dental problems
21. [ ] Hoarseness
22. [ ] Other

PULMONARY

23. [ ] Asthma
24. [ ] COPD
25. [ ] Tuberculosis
26. [ ] Pneumonia
27. [ ] Difficulty breathing/shortness of breath
28. [ ] Wheezing
29. [ ] Chronic cough or phlegm
30. [ ] Coughed up blood
31. [ ] Other

GASTROINTESTINAL

32. [ ] Appendicitis
33. [ ] Jaundice, Hepatitis or Cirrhosis
34. [ ] Ulcer
35. [ ] Gallbladder disease
36. [ ] Colon polyps
37. [ ] Hemorrhoids
38. [ ] Poor appetite
39. [ ] Abdominal pain
40. [ ] Black or bloody stool
41. [ ] Frequent heartburn
42. [ ] Frequent bloating or gas
43. [ ] Frequent nausea or vomiting
44. [ ] Frequent diarrhea or constipation
45. [ ] Difficult swallowing
46. [ ] Other

CARDIOVASCULAR

47. [ ] Heart disease
48. [ ] High cholesterol or triglycerides
49. [ ] High blood pressure
50. [ ] Stroke
51. [ ] Rheumatic fever
52. [ ] Chest pain
53. [ ] Irregular/rapid heartbeat
54. [ ] Fainting/light headedness
55. [ ] Ankle swelling
56. [ ] Varicose veins
57. [ ] Other

BLOOD/LYMPH

58. [ ] Anemia
59. [ ] Bleeding disorder
60. [ ] Enlarged lymph nodes
61. [ ] Other

Craig Abrams, D.C.

4424 Jasmine Ave
Culver City, CA 90232

## CMH -page 2

Patient: _____ Date: _____
Last, First MM/DD/YYYY

SKIN
62. [ ] Change in mole
63. [ ] Itching or rash
64. [ ] Other

GENITOURINARY
65. [ ] Kidney disease or stones
66. [ ] Sexually-transmitted disease
67. [ ] Sexual difficulties
68. [ ] Frequent or painful urination
69. [ ] Bloody or discolored urine
70. [ ] Incontinence
71. [ ] Other

MALE SPECIFIC
72. [ ] Prostate disease
73. [ ] Testicular pain or swelling
74. [ ] Impotence/erectile dysfunction
75. [ ] Difficulty urinating
76. [ ] Other

FEMALE SPECIFIC 77. [ ] Date last period began:
78. _____ _____
79. [ ] Live births
80. [ ] Miscarriage or abortion
81. [ ] Painful periods
82. [ ] Irregular or heavy periods
83. [ ] Breast lump or pain
84. [ ] Hot flashes
85. [ ] Other

NEUROLOGIC/PSYCH
86. [ ] Epilepsy or seizures 87. [ ] Headache
88. [ ] Psychiatric disorder
89. [ ] Weakness
90. [ ] Numbness/tingling
91. [ ] Dizziness
92. [ ] Tremor or twitching
93. [ ] Arm/leg pain
94. [ ] Depression or anxiety
95. []Other

MUSCULOSKELETAL
96. [ ] Fracture or dislocation
97. [ ] Arthritis
98. [ ] Scoliosis/spinal curve
99. [ ] Neck or upper back pain
100. [ ] Lower back pain
101. [ ] Swollen/painful joint(s)
102. [ ] Other

CHILDHOOD DISEASE
103. [ ] Measles
104. [ ] Mumps
105. [ ] Chicken pox
106. [ ] Other

TRAUMA
107. [ ] Motor vehicle accident
108. [ ] Other

HOSPITALIZATIONS & SURGERIES (List Date & Reason)
109. [ ] _____
110. [ ] _____
111. [ ] _____

SOCIAL HISTORY
112. [ ] Smoking/tobacco use
113. [ ] Alcohol use
114. [ ] Recreational drug use
115. [ ] Sexually active with multiple partners
116. [ ] Are you married/partnered?
117. [ ] Yes [ ] No

FAMILY HISTORY
118. [ ] Kidney disease
119. [ ] heart disease or stroke
120. [ ] High blood pressure
121. [ ] Cancer
122. [ ] Thyroid disease
123. [ ] Diabetes
124. [ ] Neurological disease
125. [ ] Musculoskeletal disease
126. [ ] Psychiatric disease
127. [ ] Other

Craig Abrams, D.C.

4424 Jasmine Ave
Culver City, CA 90232

## Patient Specific Functional Scale

Patient: _____ DOB: _____ Date: _____
Last, First MM/DD/YYYY
MM/DD/YYYY

In your visits here we want to know what 3 activities in your life you are unable to do or are having the most difficulty with as a result of your chief problem.

Please list 3 activities you are unable to perform or are having the most difficulty with because of your chief problem.

1._____
2._____
3. _____

**Activity #1**
Patient Specific Activity Scoring Scheme (circle 1 number)

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform Activity — Able to perform at same level prior to injury or problem

**Activity #2**
Patient Specific Activity Scoring Scheme (circle 1 number)

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform Activity — Able to perform at same level prior to injury or problem

**Activity #3**
Patient Specific Activity Scoring Scheme (circle 1 number)

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform Activity — Able to perform at same level prior to injury or problem

# Craig Abrams, D.C.

4424 Jasmine Ave
Culver City, CA 90232

---

Our goal is to work together with you to "problem-solve" ways to return you to the activities which you have told us you are either unable to perform or are giving you the most difficulty since this problem began

Patient: _____ DOB:_____ Date:_____
Last, First MM/DD/YYYY MM/DD/YYYY

1 Please indicate your usual level of pain during **the past week?**

No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2 Does pain, numbness, tingling or weakness **extend** into your leg (from low back) and/or arm (from neck)?

None of the time 1 2 3 4 5 6 7 8 9 10 All of the time

3 How would you **rate your general health?** (10-x)

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

4 If you had to spend the rest of your life with your **condition as it is right now,** how would you feel about it?

Delighted 1 2 3 4 5 6 7 8 9 10 Terrible

5 How anxious (eg. Tense, uptight, irritable, fearful) have you been feeling during **the past week?**

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely anxious

6 How much have you been able to control (i.e. reduce/help) your pain/discomfort on your own during **the past week?**

I can reduce it 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

7 Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, low spirits) have you been feeling **this past week?**

Not depressed at all 1 2 3 4 5 6 7 8 9 10 Extremely depressed

8 On a scale of 0-10, how certain are you that you will be doing normal activities or working in **six months?**

Very certain 1 2 3 4 5 6 7 8 9 10 Not certain at all

9 I can do light work for an hour?

Completely agree 1 2 3 4 5 6 7 8 9 10 Completely disagree

10 I can sleep at night.

Completely agree 1 2 3 4 5 6 7 8 9 10 Completely disagree

11 An increase in pain is an indication that I should stop doing what I am doing until the pain decreases.

Completely disagree 1 2 3 4 5 6 7 8 9 10 Completely agree

12 Physical activity makes my pain worse.

Completely disagree 1 2 3 4 5 6 7 8 9 10 Completely agree

13 I should not do my normal activities including work with my present pain.

Completely disagree 1 2 3 4 5 6 7 8 9 10 Completely agree

**Please sign your name _____**