Tri-Lakes Chiropractic, PC
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Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
PLEASE PRINT CLEARLY

Today's Date (MM/DD/YYYY) _____ **Patient Number (Office Use Only)** _____

Whom may we thank for referring you? _____ **Have you consulted a chiropractor before?** NO ◯ YES ◯ **If so, Whom?** _____

Your Last Name _____ **First Name** _____ **Middle Name (or Initial)** _____ **Birthday (MM/DD/YYYY)** _____

Street Address _____ **Social Security Number** _____ **Age** _____

Mailing if Different _____ **Race/Ethnicity** _____ **Language Preferred** _____

City _____ **State** _____ **Zip Code** _____

Gender ◯ Male ◯ Female

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Home Phone Number _____ **Cell Phone Number** _____

Email Address _____

Patient Occupation _____ **Patient Employer** _____

Work Number _____ **May we contact you at work?** ◯ Yes ◯ No

Employer Address _____

City _____ **State** _____ **Zip** _____

Spouse's Name _____

Child's Name _____ **Age** _____

Child's Name _____ **Age** _____

Child's Name _____ **Age** _____

Emergency Contact _____ **Phone Number** _____

Primary Care Physician Name _____

Insurance Provider Name _____ **Policy Number** _____

Insured's Last Name _____ **Insured's First Name** _____ **Insured's Middle Name (Or Initial)** _____

Insured's Birthday (MM/DD/YYYY) _____ **Who carries this policy?** ◯ **Self** ◯ **Spouse** ◯ **Parent**

Insured's Employer _____

Employer's Address _____ **City** _____ **State** _____ **Zip** _____

CONFIDENTIAL HEALTH INFORMATION

Patient name

1. **The symptom(s) that have prompted me to seek care today include:**

_____

2. **And are the result of (darken circle):**
◯ An accident or injury ◯ Work ◯ Auto ◯ Other: _____

3. **Onset** (When did you first notice your current symptoms) : _____

4. **Intensity** (How extreme are your current symptoms?)

Absent — Uncomfortable — Agonizing

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

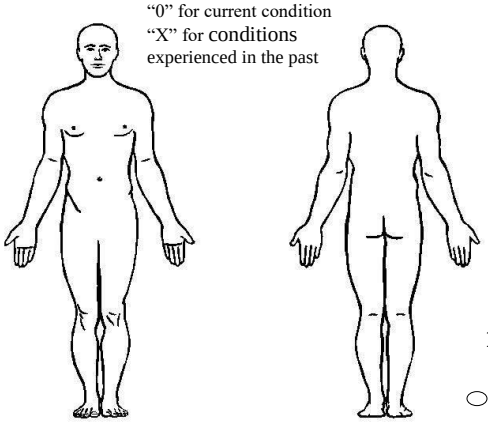
5. **Duration & Timing** (When did it start and how often do you feel it?)
◯ Constant ◯ Comes & goes. How often? _____

6. **Quality of Symptoms** (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other

7. **Location (**Where does it hurt?)
Circle the area on the illustration below

"0" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the the pain radiate, shoot or travel)

_____

9. **Aggravating or relieving factors**
(What makes it worse or better, such as time of day, movements, certain activities, etc.

_____

What tends to worsen the problem?

_____

What tends to lessen the problem?

_____

10. **Prior interventions** (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Heat
◯ Over-the-counter drugs ◯ Acupuncture ◯ Ice
◯ Homeopathic remedies ◯ Chiropractic ◯ Massage
◯ Physical Therapy ◯ Other: _____

11. **What is your preferred sleeping position?**

_____

12. **Review of System**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your body. Please check the circle above any condition that you've **HAD** or currently **HAVE. Please initial to the right**

A. Musculoskeletal

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ _____ Initials

B. Neurological

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins & needles	◯	◯	Numbness

NONE ◯ _____ Initials

C. Cardiovascular

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Excessive bruising	◯	◯	Angina

NONE ◯ _____ Initials

D. Respiratory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ _____ Initials

E. Digestive

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitives	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ _____ Initials

F. Sensory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ _____ Initials

G. Skin

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ _____ Initials

H. Endocrine

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Thyroid issues	◯	◯	Immune disorder	◯	◯	Hypoglycemia	◯	◯	Frequent infection	◯	◯	Swollen glands	◯	◯	Low energy

NONE ◯ _____ Initial

I. Genitourinary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
◯	◯	Kidney stones	◯	◯	Infertility	◯	◯	Bedwetting	◯	◯	Prostate issues	◯	◯	Erectile dysfunction	◯	◯	PMS symptoms

NONE ◯ _____ Initial

Doctor's Initials

J. Constitutional

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss	○	○	Weakness	_____ Initial

Patient name

13. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

14. What else should Tri-Lakes Chiropractic know about your current condition? _____

_____

Past Personal Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments .

PERSONAL

15. Illnesses

Check the illnesses you've **Had** or **Have** now.

Had	Have	
○	○	Aids
○	○	Alcoholism
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other: _____

16. Operations

Surgical interventions, which may or may not include hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective _____
- ○ Eye Surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other _____

19. Allergies

Are you allergic to any medications?

○ No ○ Yes

If yes please list:

_____

17. Treatments

Check the ones you have received in the **Past** or are receiving **Currently.**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone therapy
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins & minerals.

_____

_____

18. Injuries Have you ever……

- ○ Had a fractured or broken bone
- ○ Used a crutch or other support
- ○ Had a spine or nerve disorder
- ○ Used neck or back bracing
- ○ Been knocked unconscious
- ○ Received a tattoo
- ○ Been injured in an accident
- ○ Had a body piercing

20. Family History Some health issues are hereditary. Tell us about the health of your immediate family.

FAMILY

Relative	Age (if living)	State of Health: Poor	State of Health: Good	Illnesses	Age at death	Cause of death
Mother	_____	○	○	_____	_____	_____
Father	_____	○	○	_____	_____	_____
Sister 1	_____	○	○	_____	_____	_____
Sister 2	_____	○	○	_____	_____	_____
Brother 1	_____	○	○	_____	_____	_____
Brother 2	_____	○	○	_____	_____	_____

21. Social History

Please tell us about your health habits and stress levels. Please circle below

SOCIAL

Alcohol	Daily	Weekly	How much? _____
Coffee use	Daily	Weekly	How much? _____
Tobacco use	Daily	Weekly	How much? _____
Exercising	Daily	Weekly	How much? _____
Pain relievers	Daily	Weekly	How much? _____
Soft drinks	Daily	Weekly	How much? _____
Water intake	Daily	Weekly	How much? _____

Prayer or meditation?	Yes	No
Job pressure/stress?	Yes	No
Financial peace?	Yes	No
Mercury fillings?	Yes	No
Recreational drugs?	Yes	No

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

_____ Initials — I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chriopractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertabral subluxation. Chiropractic is a separate and distinctive healing art from medicine and does not proclaimto cure any named disease or entity.

_____ Initials — I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbusment from any involved third parties.

_____ Initials — I realize and X-ray examination may be hazordous to an unborn child and I certify to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

_____ Initials — I grant premission to be called to confirm or reschedule and appointment and to be sent occasional cards, letters, emails or health information to me a an extention to my care in this office.

_____ Initials — I acknowledge that any insurance I may have is an agreement between the carrier and me and I am responsible for the payment of any covered or non-covered services I receive.

_____ Initials — To the best of my ability, the information I have supplied is complete and truthful, I have not misrepresented the presence, severity or cause of my health concern.

Print patient's full name : _____

Signature: _____ **Date:** _____

Doctor's Initials