Welcome To Trestman Chiropractic

How did you hear about our office? ____________________________

Have you ever been under chiropractic care before? ❑No ❑Yes. If yes, please explain: ____________________

PATIENT DATA (Print Legibly)

Name ____ Email ______________________________
For general office announcements and promotions ONLY.

Address ________________________________ City ___________________ State ________ Zip __________

Phone (Cell) _____________________ (Home) ______________________ (Work) ____________________

Age ______ Birth Date __________ Sex ❑M ❑F Occupation _________________ Hrs worked per week _____

Emergency Contact _____________________________ Relationship __________Phone __________________

CURRENT COMPLAINTS

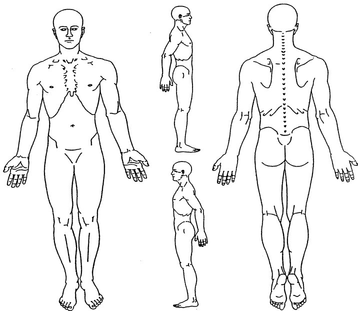
Have you seen other doctors for this condition? ❑No ❑Yes___________

Reason for Visit ____

How long has it been since you really felt good? ____

Is this condition due to an accident? ❑No ❑Yes. If yes what type? ❑Auto ❑Work ❑Home ❑Other ___________

Mark an X on the picture where you have pain or discomfort.



When did your symptoms first appear? ______________________________________

What caused this complaint or how did you do it? ______________________________________

____

What aggravates or makes the condition worse? ______________________________________

Is this condition getting progressively worse: ❑Yes ❑No ❑Uncertain ❑Other _________

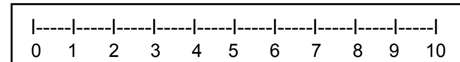
What relieves or makes the condition better? ______________________________________

Type of pain or discomfort: ❑Sharp ❑Dull ❑Ache ❑Throb ❑Numbness ❑Shooting ❑Burning ❑Tingling ❑Tight ❑Swelling ❑Stabbing ❑Itching ❑Other ______________________________

Overall Frequency of complaint: ❑Constant 100% of the time ❑Frequent 75% ❑Intermittent-50% ❑Occasional-25%

Does it interfere with ❑Work ❑Sleep ❑Daily Routine ❑Recreation ❑Other ________________________

Circle the severity of your pain at its BEST and at its WORST.
Use the scale of <u>Zero (no pain)</u> to <u>10 (severe pain)</u>.



What are your hobbies (indoors & outdoors)? ____

How much time each day do you use the computer at work? ___________________ At home? __________________

What makes you stressed? ______________________ What makes you happy? ______________________________

List 3 goals you want to achieve through chiropractic care:

1. ____________________________ 2. ____________________________ 3. ____________________________

FINANCIAL AGREEMENT

Do you have health insurance ❑No ❑Yes If yes ❑PPO ❑HMO ❑Other

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider (Trestman Chiropractic) for services rendered. **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally and financially responsible for payment whether or not paid by insurance.**

____ ______________

Patient or Guardian Signature Date of First Visit

Name (again): ____ Date of Birth (again): ___________

HEALTH HISTORY

Please check each of the conditions that you have now or had in the past.

- ❑AIDS/HIV
- ❑Alcohol/Drug Abuse
- ❑Allergies
- ❑Arthritis
- ❑Arm Pain/Tingling
- ❑Asthma
- ❑Bleeding Disorders
- ❑Breast Lump
- ❑Cancer
- ❑Chemotherapy/Radiation
- ❑Constipation
- ❑Digestive Problems
- ❑Dizziness/Vertigo
- ❑Eating Disorder
- ❑Feet Pain/Tingling
- ❑Hand Pain/Tingling
- ❑Headaches
- ❑Heart Attack/Stroke
- ❑Heart Surgery/Pacemaker
- ❑Heart Murmur
- ❑Hepatitis
- ❑High/Low Blood Pressure
- ❑Herniated Disk
- ❑High Cholesterol
- ❑Irritable Bowel
- ❑Jaw Pain
- ❑Loss of Sleep
- ❑Lower Back Problems
- ❑Mid Back Problems
- ❑Migraines
- ❑Multiple Sclerosis
- ❑Neck Pain
- ❑Numbness ___________
- ❑Osteoporosis/Osteopenia
- ❑Parkinson's Disease
- ❑Psychiatric Condition
- ❑Sciatica
- ❑Shingles
- ❑Shoulder Pain/Tingling
- ❑Stroke
- ❑Tuberculosis
- ❑Tumors/Growths
- ❑Ulcers/Colitis
- ❑Pain that wakes you up at night
- ❑(Men) Prostate Conditions
- ❑Motor Vehicle Accident
- ❑Other ________________

For Women:

Is there a chance you are Pregnant? ❑No ❑Yes How many weeks? ____________

Do you suffer from PMS ❑No ❑Yes

Do you have breast implants? ❑No ❑Yes

Injuries/Surgeries you have had:	Description	Date
Falls	____________________	__________
Head Injuries	____________________	__________
Broken Bones/Dislocations	____________________	__________
Surgeries	____________________	__________

Lifestyle Habits:

Tobacco (#/day) _____ Coffee (cups/day) _____ Sleep (hrs/day) _____ Water (oz/day) _____

Alcohol* (drinks/day) _____ Tea (cups/day) _____ Soft Drinks (cans/day) _____ ❑Diet or ❑Regular

Exercise: Type ________________________ Frequency ______________

________________________ ______________

*1 Drink = 1.5oz liquor, or 12oz beer, or 6oz wine

FAMILY HISTORY

Tell us about the major health conditions of your immediate family.

Family Member Relation:	Health Problem:
______________	______________________________
______________	______________________________
______________	______________________________

MEDICATIONS TAKEN NOW

List prescription, nonprescription, vitamins, minerals, herbs & supplements etc.

Name:	Purpose:	How Long Taken?:
______________	______________	______________
______________	______________	______________
______________	______________	______________

Height _________ Weight __________