TRINITY CHIROPRACTIC

10101 Taylorsville Rd. Suite 101 Louisville, KY 40299 Phone: (502) 267-3040 Fax: (502) 267-0415

PATIENT INFORMATION

Full Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ - _____

Cell Phone: (_____) - _____ - _____

Work Phone: (_____) - _____ - _____ Ext: _____

Email: _____

Number of Children: _____

Children's Names

Ages

_____ _____

_____ _____

_____ _____

HOW DID YOU HEAR ABOUT US?

_____

Date of Birth: ____/____/____ Sex: M F Age: _____

Social Security #: _____

School: _____

Parent/Guardian Name: _____

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Occupation: _____

Parent/Guardian Date of Birth: ____/____/____

Spouse's Name: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home/Cell Phone: (_____) - _____ - _____

Work Phone: (_____) - _____ - _____ Ext:_____

PAYMENT INFORMATION

Who is responsible for this account?: _____

Relationship to patient: _____

Insurance Company: _____

Policy #: _____

Group#: _____

Date of Birth of Policy Holder: _____/_____/_____

(This information is necessary to verify your insurance benefits)

For PERSONAL INJURY or WORKERS' COMPENSATION

Insurance Company: _____

Claim #: _____

Have you retained an attorney? Y N

Attorney Name: _____

Attorney Phone #: _____

Attorney Address: _____

_____

OTHER DOCTORS & PHYSICIANS

Previous Chiropractor: _____

Date of Last Visit: _____

Reason for Leaving: _____

Primary Care Provider: _____

Office Name: _____

Phone #: _____

(PEDIATRIC – AGE UNDER 12)

Dr. Initials: _____

TRINITY CHIROPRACTIC HISTORY FORM

Name:_____ DOB:_____ Date:_____ File #: _____

PATIENT CONDITION

Please describe only one area at a time from most severe to least severe (ex: neck, mid-back, low back)

Chief Complaint: _____

_____

Where is the pain? _____

When did your symptoms appear? _____

What caused this condition? _____

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Unknown

Rate the severity of your pain (10 = severe): 1 2 3 4 5 6 7 8 9 10

Describe the pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting

❒ Burning ❒ Tingling ❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other: _____

How often is this pain? ❒ Constantly ❒ Frequently ❒ Occasionally ❒ Intermittently

(% of day): (100%) (75%) (50%) (25%)

How long do the symptoms last? _____ seconds minutes hours days weeks

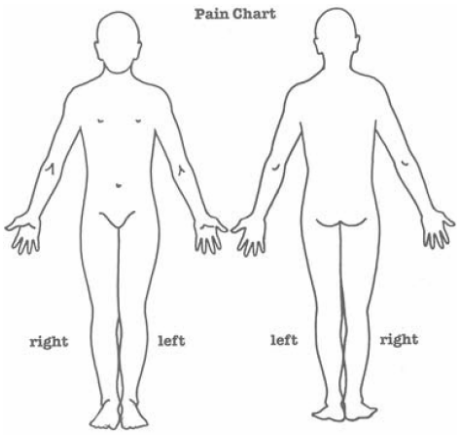
Does this condition radiate/refer to other areas? _____

What makes it worse? _____

What makes it better? _____

Is this problem due to: ❒ Auto Accident ❒ Work Injury

What have you done to relieve the symptoms?_____



(Mark the picture above where you are feeling pain)

○ Aching Pain

△ Sharp Pain

□ Burning Pain

X Numbness/Tingling

PATIENT CONDITION

Please describe only one area at a time (ex: neck, mid-back, low back)

Secondary Complaint: _____

_____

Where is the pain? _____

When did your symptoms appear? _____

What caused this condition? _____

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Unknown

Rate the severity of your pain (10 = severe): 1 2 3 4 5 6 7 8 9 10

Describe the pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting

❒ Burning ❒ Tingling ❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other: _____

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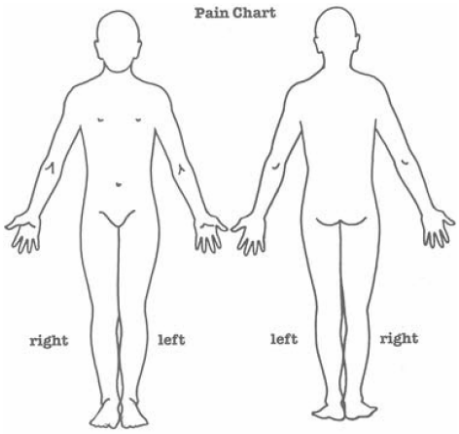

(Mark the picture above where you are feeling pain)

○ Aching Pain

△ Sharp Pain

□ Burning Pain

X Numbness/Tingling

(PEDIATRIC – AGE UNDER 12)

Dr. Initials: _____

TRINITY CHIROPRACTIC HISTORY FORM

Name:_____ DOB:_____ Date:_____ File #: _____

HEALTH HISTORY

Injuries/Surgeries you have had:			**Description**	**Date**
Auto Accident	❒ Yes	❒ No	_____	_____/_____/_____
Slips/Falls	❒ Yes	❒ No	_____	_____/_____/_____
Broken Bones	❒ Yes	❒ No	_____	_____/_____/_____
Surgeries	❒ Yes	❒ No	_____	_____/_____/_____
Vaccines	❒ Yes	❒ No	_____	_____/_____/_____

Current Medications:	**For what?**	**Please mark the details of the birth process:**
_____	_____	❒ Midwife ❒ Hospital ❒ Obstetrician
_____	_____	❒ Vaginal ❒ C-Section ❒ Forceps ❒ Vacuum Extraction
_____	_____	❒ Induced ❒ Epidural ❒ Obstetrician
_____	_____	❒ Breastfeed ❒ Formula APGAR Score: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

❒ AIDS/HIV	❒ Chicken Pox	❒ Measles
❒ Allergies	❒ Colic	❒ Migraine Headaches
❒ Anemia	❒ Constipation	❒ Mononucleosis
❒ Anorexia	❒ Diarrhea	❒ Multiple Sclerosis
❒ Appendicitis	❒ Dizziness	❒ Mumps
❒ Ashma	❒ Ear Infections	❒ Numbness Arms/Hands/Legs
❒ Bed Wetting	❒ Epilepsy	❒ Pneumonia
❒ Bleeding Disorder	❒ Frequent Colds/Flu	❒ Polio
❒ Bronchitis	❒ Heart Disease	❒ Psychiatric Care
❒ Cancer	❒ Hepatitis	❒ Rheumatic Fever

Please list any other health problems you have:_____

FAMILY HISTORY

Please indicate which conditions have been experienced by your family members by marking appropriate boxes (**M**=Mother & **F**=Father)

Father: living deceased COD: _____ **Mother**: living deceased COD: _____

M	**F**		**M**	**F**		**M**	**F**	
❒	❒	Cancer _____	❒	❒	Tuberculosis	❒	❒	Asthma
❒	❒	Diabetes	❒	❒	Mental Illness	❒	❒	Arthritis
❒	❒	Stroke	❒	❒	Kidney Disease	❒	❒	Epilepsy
❒	❒	Heart Attack/Disease	❒	❒	Lung Disease	❒	❒	Other: _____
❒	❒	Thyroid Disease	❒	❒	Liver Disease	❒	❒	Other: _____

SOCIAL HISTORY

EXERCISE:

❒ Aerobic ❒ Weight lifting ❒ Run/Jog ❒ Walk ❒ Yoga

❒ Other: _____

How often?:_____

HOBBIES: _____

_____

❒ Smoking	Packs/Day: _____
❒ Alcohol	Drinks/Week: _____
❒ Coffee/Caffeine	Drinks Cups/Day: _____
❒ Drugs	Type: _____
❒ High Stress	Reason: _____

TRINITY CHIROPRACTIC HISTORY FORM

Name:_____ DOB:_____ Date:_____ File #: _____

REVIEW OF SYSTEMS

Please **check Yes or No** to indicate if you currently have any problems in one or more of the following areas?
If yes, please circle the problem listed and explain or describe the problem.

SYSTEM	EXAMPLES	YES/NO	DESCRIPTION
GENERAL/CONSTITUTIONAL	Fever Weight loss/gain Tired feeling	❒ Yes ❒ No	_____ _____
EYES	Blurred vision Eye pain Eye discharge	❒ Yes ❒ No	_____ _____
EARS, NOSE, THROAT, MOUTH	Hearing loss Ear ache Nasal congestion, Chronic cough Dry mouth Allergies/Hay fever	❒ Yes ❒ No	_____ _____ _____ _____
RESPIRATORY	Asthma Emphysema Chronic bronchitis Wheezing Shortness of breath	❒ Yes ❒ No	_____ _____ _____
CARDIOVASCULAR	Diabetes Hypertension Heart problems	❒ Yes ❒ No	_____ _____
GASTROINTESTINAL	Diarrhea Constipation Hernia Ulcers	❒ Yes ❒ No	_____ _____
GENITOURINARY	Painful urination Frequent urination Impotence Jaundice	❒ Yes ❒ No	_____ _____
LYMPHATIC	Anemia Bleeding problems Blood transfusions	❒ Yes ❒ No	_____ _____
MUSCULOSKELETAL	Arthritis Joint pain Muscle pain Cramps Stiffness Swelling	❒ Yes ❒ No	_____ _____ _____
SKIN	Pimples Warts Growths Rashes	❒ Yes ❒ No	_____ _____