TRINITY CHIROPRACTIC

9204 Taylorsville Rd. Suite 110, Louisville, KY 40299 Phone: (502) 267-3040 Fax: (502) 267-0415

File: TJ

PATIENT INFORMATION

Full Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ - _____

Cell Phone: (_____) - _____ - _____

Email: _____

Do you want reminders? ❒ Text ❒ Email ❒ Call

Cell Phone Carrier (for text reminders):_____

Children's Names

Ages

_____ _____

_____ _____

_____ _____

HOW DID YOU HEAR ABOUT US?

_____

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

Social Security #: _____

Occupation: _____

❒ Full-time ❒ Part-time ❒ Unemployed ❒ Retired

Employer: _____

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Employer: _____

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 #: _____

Dr. Initials: _____

TRINITY CHIROPRACTIC HISTORY FORM

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

ACCIDENT HISTORY

Vehicles Involved:

Your Vehicle	**Other Vehicle**	
Year: _____	Year: _____	Date of Accident: _____
Make: _____	Make: _____	Time of Accident: _____ AM PM
Model: _____	Model: _____	Location of Accident: _____
Speed: _____	Speed: _____	_____
Size: ❒ Small ❒ Mid ❒ Large	Size: ❒ Small ❒ Mid ❒ Large	

Accident Type: ❒ Rear-ended ❒ Head-on ❒ Broad-sided

Describe the accident (in detail): _____

Specifics of the accident:

Were you the:	❒ Driver	❒ Passenger
Sitting in the:	❒ Front Seat	❒ Back Seat
Were you wearing a seatbelt?:	❒ Yes	❒ No
Did the airbag deploy?:	❒ Yes	❒ No
Did the impact surprise you?:	❒ Yes	❒ No
Were you facing forward?	❒ Yes	❒ No
Did you brace for the impact?	❒ Yes	❒ No _____
Did your head strike an object?	❒ Yes _____	❒ No
Position of the headrest to head?	❒ High ❒ Middle	❒ Low
Did you experience any:	❒ Loss of Consciousness ❒ Nausea/Vomiting	
	❒ Dizziness ❒ Bleeding ❒ Go into shock	
	❒ See flash of light on impact	

Time Loss:

Have you had any missed work due to injuries from the accident? ❒ Yes ❒ No

How long have you been off work?: _____ (days/weeks/months)

Do you work with limitations? ❒ Yes ❒ No

What limitations?: _____ _____

Immediately following the accident:

❒ Ambulance/Paramedics were called _____

❒ Transported to the Hospital by Ambulance _____

❒ Went to the Hospital on my own _____

❒ Diagnostics/Treatment performed at Hospital _____

❒ Medication was prescribed: _____

Did you feel pain *immediately* following the accident?

❒ Yes ❒ No

ACTIVITIES OF DAILY LIVING

Mark all that apply since the accident:

❒ Has difficulty turning over in bed.
❒ Has to lie down/sit to rest frequently.
❒ Changes position frequently
❒ Does not do jobs around the house.
❒ Walks more slowly than usual.
❒ Can only walk short distances.
❒ Has difficulty climbing stairs.
❒ Has to use handrails to get up stairs
❒ Has difficulty bending/kneeling.
❒ Only stand for short periods of time.
❒ Holds something to sit/rise from chair
❒ Must get others to do things for you.
❒ Has difficulty getting dressed.
❒ Has difficulty sleeping.

List hobbies/recreations you are unable to perform or limited in since the injury:

_____ _____

How does the problem(s) interfere with

Work: _____

Family: _____

Sleep: _____ hrs/night ____

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

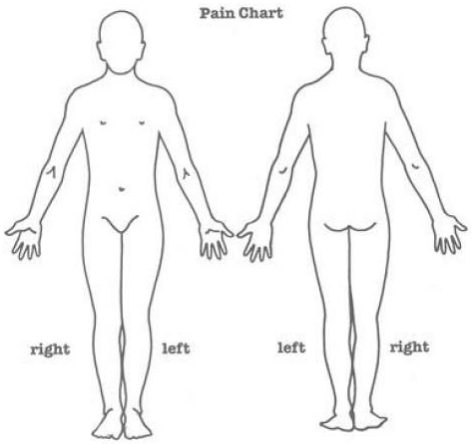
Does this condition radiate/refer to other areas? _____

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: _____

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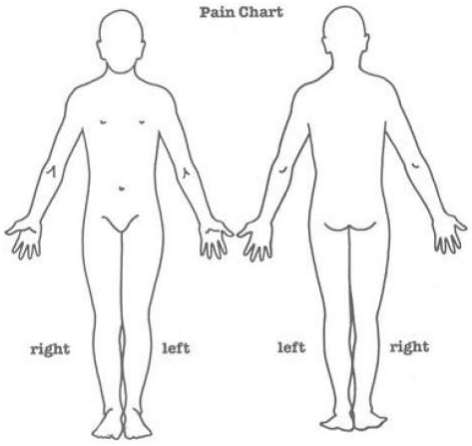

(Mark the picture above where you are feeling pain)

○ Aching Pain

△ Sharp Pain

□ Burning Pain

X Numbness/Tingling

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	_____	_____/_____/_____
Hospitalized	❒ Yes	❒ No	_____	_____/_____/_____
Other:			_____	_____/_____/_____

Current Medications:	**For what?**	**Facility of your last**:	**Date**
_____	_____	X-RAY _____	_____
_____	_____	MRI _____	_____
_____	_____	CT _____	_____
_____	_____	BONE SCAN _____	_____

PAST MEDICAL HISTORY

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

❒ High/Low Blood Pressure	❒ Alcoholism	❒ Congenital Disease _____
❒ Circulatory Problems	❒ Osteoarthritis	❒ Gall Bladder
❒ Cancer (type)_____	❒ Rheumatoid Arthritis	❒ Ulcers
❒ Strokes	❒ Pace Maker	❒ Excessive Bleeding
❒ Broken or Fractured Bones	❒ Seizures/Convulsions	❒ Coughing Blood
❒ Eating Disorder	❒ Drug Addiction	❒ Hernia _____
❒ Epilepsy	❒ AIDS/HIV Positive	❒ Depression

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	