CONFIDENTIAL PATIENT HISTORY

Full Name:_____ Gender: M / F Email:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Height:_____ Weight:_____ Age:_____ Date of Birth:_____ SS#:_____

Marital Status: Married Single Widowed Divorced Are you pregnant? Y / N / Unsure No. of Children:_____

Occupation:_____ Employer:_____ Employer Phone:_____

Name of Spouse/Guardian:_____ Date of Birth:_____ Phone #:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Circle: Rt Handed / Lt Handed / Ambidextrous Whom may we thank for referring you to our office? _____

Have you ever received chiropractic care? Yes / No If so, When was your last visit? _____

Were you satisfied with the care you received? Yes / No How could it have been better? _____

PATIENT CONDITION

What is your chief concern, or the reason for today's visit?_____ Right / Left / Both Sides

When did your symptoms appear? _____ Did anything contribute to the onset of your condition? _____

Is your condition getting progressively worse? Yes / No / Unknown

Is your condition worse in the: A.M. / P.M. / All the time / Doesn't Apply / Other _____

Does your condition interfere with: Work / Sleep / Daily Routine / Recreation / Other _____

Describe your Discomfort: Achy / Burning / Cramping / Dull / Numbness / Sharp / Shooting / Stiffness / Swelling / Tingling

Does your discomfort radiate or travel? Yes / No If so, where? _____

Rate your discomfort (1 = minimal discomfort and 10 = severe pain) Now_____ At its worse_____

What percentage of the time do you feel your discomfort? 0-25% / 26-50% / 51-75% / 76-100%

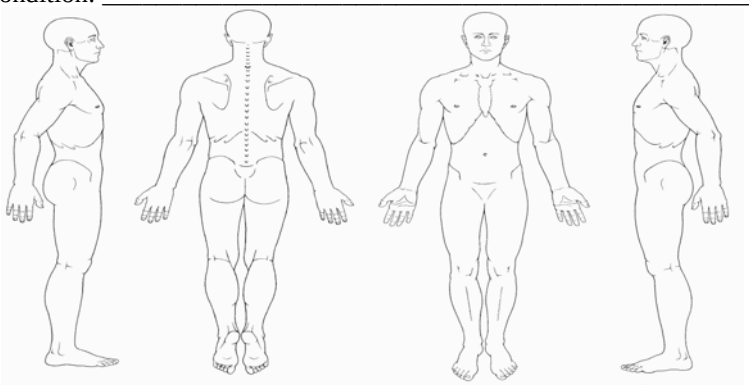
Activities or movements that are painful/ aggravate your condition: Bending / Lying Down / Sitting / Standing / Walking

What activities / movements / medications make your condition fell better? Nothing / Other:_____

Have you had this exact same condition before? Yes / No If so, When?_____

Other Physicians, DC's, or Therapist seen for this condition: _____

Please mark off the areas of your present complaint on the diagrams to your right.



MEDICAL HISTORY

Please circle the following conditions you may have had in the past or have now:

Alcoholism	Convulsions	Gout	Migraine	Rubella
Allergies	Depression	Headaches	Miscarriage	Scoliosis
Anemia	Diabetes	Heart Attack	Multiple Sclerosis	Sinus Trouble
Arthritis	Diarrhea	Heart Disease	Mumps	Stroke
Back Pain	Ear Infections	High Blood Pressure	Neck Pain	Thyroid Problems
Bladder Infections	Eczema	Irregular Periods	Nervousness	Tuberculosis
Blood Vessel Disease	Epilepsy	Kidney Disease	Neuritis	Ulcers
Cancer	Fainting	Low Blood Sugar	Pleurisy	Uterine Cyst/Tumors
Chicken Pox	Flat Feet	Malaria	Pneumonia	Venereal Disease
Cold Sores	Gall Bladder Disease	Measles	Polio	Whooping Cough
Constipation	Glaucoma	Menstrual Cramps	Roseola	Other_____

MEDICATIONS/VITAMINS/HERBS
Please list any medications you are currently taking

_____

_____

_____

ALLERGIES
Please list any known allergies you are aware of

_____

_____

_____

Women Only: Date of last menstrual period _____ Are you pregnant? Y / N Are you nursing? Y / N

HEALTH HISTORY

Please identify all facilities and providers you have seen for these or any other conditions you have had in the past or present.

Dr Name or Facility	Condition/Problem	Treatment Received	From When to When

Injuries/Surgeries you have had: (Please give description and approximate date)

	Description	**Date**
Motor Vehicle Accidents:	_____	_____
Any Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____
Other Serious Injuries:	_____	_____

The above information is accurate and complete to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Kevin Smith or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I authorize Dr. Kevin Smith to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Trinity Family Chiropractic, PC all insurance benefits otherwise payable to me.

PRINT NAME _____SIGNATURE_____DATE_____