

Whom may we thank for referring you to this office → _____?

NEW PATIENT CARE FORM AT



TriStar Family Chiropractic

A FAMILY WELLNESS CENTER

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Identification/Driver's License #: (copy of ID will be made at time of appointment) _____

Employer: _____ Occupation: _____

Number of Children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its **worst**? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

Is your problem the result of ANY type of accident? Yes No **If yes**, circle one: WORK ACCIDENT CAR ACCIDENT SPORTS OTHER

Condition(s) ever been treated by anyone in the past? Yes No **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results?

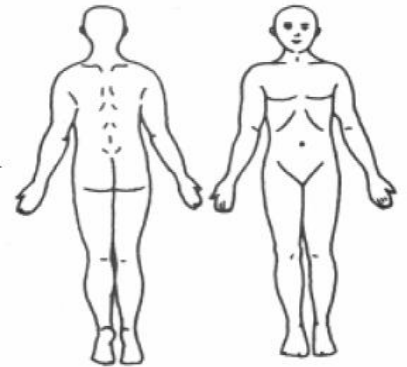
Name of Previous Chiropractor: _____ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

EXAMPLE: Walking

¼ Mile

2 Miles

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Identify any other injury(s) to your spine, minor or major, including childhood traumas that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen? _____ Does anyone in your family suffer with the same condition(s)? No Yes

Other forms of treatment tried: No Yes **If yes**, please state **what** type of treatment you have tried: _____, and who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs/hobbies you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with the following **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

___ Fracture/Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular/Stroke ___ Other serious conditions:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

1. **Smoking:** cigars pipe cigarettes → How often? Daily Weekends Occasionally Never

2. **Alcoholic Beverage:** consumption occurs → Daily Weekends Occasionally Never

3. **Recreational Drug use:** Daily Weekends Occasionally Never

Do you have a Current Physician Issues Medical Marijuana Card? No Yes

4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following: _____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? No Yes

If yes whom: grandmother grandfather mother father sister's brother's son(s) daughter(s)

Have they ever been treated for their condition? No Yes I don't know

2. **Any other hereditary conditions the doctor should be aware of.** No Yes: _____

I hereby authorize payment to be made directly to **Tristar Family Spine and Wellness Center**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **Tristar Family Spine and Wellness Center** for any and all services I receive at this office.

Patient or Authorized Person's Signature

Date Completed

Doctor's Signature

Date Form Reviewed

Office Use: Patient's Name: _____ HR#: _____ ___/___/___ JDD,DC 5/2011

TRISTAR FAMILY CHIROPRACTIC, A Family Wellness Center

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting (long periods)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing(long periods)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Grooming/Personal Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercise	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Patient signature: _____ Today's Date: ___/___/___

Office Use: Patient's Name: _____	HR#: _____	___/___/___	JDD,DC 5/2011
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Please mark P for in the Past, C for Currently have and N for Never

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble | |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) | |
| <input type="checkbox"/> Cancer: Breast/Liver/Thyroid/Prostate/Cervical/Skin | <input type="checkbox"/> Other : _____ | | | |

List Supplements, Prescription & Non-Prescription drugs you take: _____

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Patient signature: _____ **Today's Date:** ___/___/___