TRI FORCE
CHIROPRACTIC
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Confidential Health Information

Patient Data Date Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial ___ Last Name _____

I prefer to be called by_____

Address Line _____ City _____

State _____ Zip Code _____

Home Phone (____) _____-_____

Work Phone (____) _____-_____

Cell Phone (____) _____-_____

Email _____

Date of Birth _____/_____/_____

Sex: Male Female

Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other____

Current Occupation Emergency Contact Name _____

Relationship to Patient _____

Contact Home Phone (____) _____-_____

Cell Phone (____) _____-_____

How did you hear about our office? _____

Medical Conditions: (List all conditions treated in the past and currently)

_____

_____

_____

Surgeries: (List all surgeries and when performed)

_____

_____

_____

Allergies: (List any allergies)

_____

_____

_____

Social History: (Check all that apply to you)

Caffeine use: occasional often never

Drink Alcohol: occasional often never

Exercise: occasional often never

Tobacco Use: occasional often never

Sleep: Hours per night= _____

Stress Level: High Moderate Low None

Family History: (Check all that apply)

Arthritis: Parent Sibling

Cancer: Parent Sibling

Diabetes: Parent Sibling

Heart Disease Parent Sibling

Hypertension Parent Sibling

Stroke Parent Sibling

Thyroid Parent Sibling

Other _____

Patient Name_____Date_____

Review of Systems – (Check if you have had trouble with any of the following within the last 3 months)

General:

___ Weight change ___ Fever ___ Chills ___ Night Sweats ___ Weakness ___ Fatigue

Skin:

___ Rash ___ Itching ___ Hair Changes ___ Nail Changes

Musculoskeletal:

___ Neck ___ Upper Extremities ___ Upper Back ___ Lower Back ___ Lower Extremities

Cardio:

___ Murmur ___ Chest Pain ___ Palpitations ___ Difficulty Breathing ___ Cough ___ Wheezing

___ Blue Extremities ___ Swollen Extremities

Gastro-Intestinal:

___ Appetite ___ Abdominal Pain ___ Vomiting ___Diarrhea ___ Constipation

Genito-Urinary:

___ Frequent Urination ___ Painful Urination ___ Incontinence

Neurologic:

___ Headache ___ Dizziness ___ Fainting ___ Convulsions

Psychologic:

___ Anxiety ___ Depression ___ Moods ___ Memory

Eyes:

___ Vision ___ Pain ___ Discharge

Ears:

___ Hearing ___ Ringing ___ Pain ___ Discharge

Nose:

___ Pain ___ Bleeding ___ Taste

Mouth/Throat:

___ Sores ___ Bleeding ___ Taste

Breasts:

___ Mass ___ Pain ___ Discharge ___ Self-exam

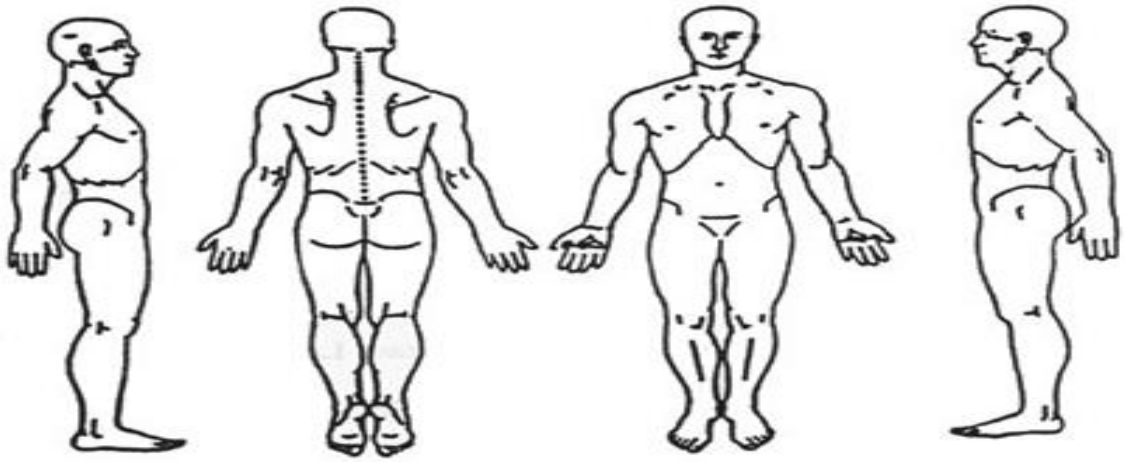
Additional Information:

Please list ALL current medications and/or supplements being taken:

Patient Name_____**Date**_____

Are you pregnant? Yes____ No _____N/A_____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Circle the Description of Your Complaint

Dull - Achy - Sore - Sharp - Shooting - Stabbing - Burning - Radiating - Tingling - Numbing - Itchy

Are your symptoms a result of:

Motor Vehicle Accident Work related Accident Other____

How are your symptoms changing?

Getting better Not changing Getting worse

Activities of Daily Living Please circle if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Position–Sit-Stand Climb Stairs

Driving Extended Computer Use Feeding Household Chores Kneeling Lift Children

Lifting Pet Care Reading (Concentration) Self Care–Bathing Self Care–Dressing

Sexual Activities Sleep Static Sitting Static Standing Walking Yard Work

Other_____

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

___ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

___ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"