

***Welcome to Trillium Health & Wellness, S.C.***

**Patient Information**

**Date:**

|  |                 |          |
|--|-----------------|----------|
| Patient Full/Legal Name:                     | Preferred Name: |          |
| Address:                                     |                 |          |
| City:  | State:          | Zip + 4: |
| Birth Date:                                  | Age:            |          |
| Marital Status:                              | Spouse's Name:  |          |
| How did you find out about Trillium?         |                 |          |
| Have you ever been to a Chiropractor before? |                 |          |
| If yes, what doctor and what for?            |                 |          |

**Employer Information**

|                   |                 |      |
|-------------------|-----------------|------|
| Occupation:       |                 |      |
| Employer:         | Employer Phone: | Ext: |
| Employer Address: | City:           | Zip: |

**Emergency Contact** *(Someone who does not live with you)*

|           |             |             |
|-----------|-------------|-------------|
| Name:     |             |             |
| Relation: | Home Phone: | Cell Phone: |

***The BEST place to call me is (circle one):***    **Home**    **Cell**    **Work**

**Home Phone:** (\_\_\_\_) \_\_\_\_\_-

- OK to leave a message with detailed information
- Leave message with contact number only

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_-

- OK to leave a message with detailed information
- Leave message with contact number only

**Work Phone:** (\_\_\_\_) \_\_\_\_\_-

- OK to leave a message with detailed information
- Leave message with contact number only

**E-mail:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Primary Care Doctor** *Please provide the following information so we can send a report.*

Doctor's Name / Practice: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_



**Review of Systems:** Please write in a number:

1. PRESENTLY HAVE 2. PREVIOUSLY HAD 3. RELATED TO ACCIDENT

**General**

- Chills
- Cancer
- Seizures
- Dizziness/Vertigo
- Fainting
- Fatigue
- Fever
- Headache
- Sleep Loss
- Weight loss/gain
- Sweats
- Anxiety
- Depression

**NeuroMusculoskeletal**

- Arthritis
- Bursitis / Tendonitis
- Numbness
- Tremors
- Pain or stiffness in:
  - Neck
  - Upper Back (between shoulder blades)
  - Low Back
  - Tailbone
  - Ribs
  - Shoulders
  - Elbows
  - Wrists
  - Hips
  - Knees
  - Ankles / Feet
- Sciatica (pain in leg)

**Ears, Nose, Throat**

- Allergy
- Asthma
- Colds
- Sore Throat
- Deafness
- Ear infection
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Hypo/Hyper thyroid
- Blindness / Blackouts
- Hoarseness

**Genito-Urinary**

- Blood/pus in urine
- Frequent urination
- Painful urination
- Dribbling
- Bladder infection
- Kidney stones
- Prostate trouble
- Hot flashes
- Lump in breast
- Abnormal Pap smears
- Hernia

**Respiratory**

- Chronic cough
- Difficulty breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

**Cardiovascular**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Racing heart beat
- Slow heart beat
- Swelling in ankles

**Gastrointestinal**

- Belching or gas
- Constipation
- Diarrhea
- Difficult digestion
- Distention of abdomen
- Excessive hunger
- Heartburn/reflux
- Gall bladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting blood

**Skin:**

- Acne
- Eczema
- Rash
- Changes in mole or freckle

**Other:** (Please describe) \_\_\_\_\_

**Family History:** Note any diseases that your relatives have had (if known):

| Relatives       | Arthritis | Cancer | Diabetes | Heart Disease | Stroke | Neurological<br>MS, Parkinson, etc. | Thyroid |
|-----------------|-----------|--------|----------|---------------|--------|-------------------------------------|---------|
| Father          |           |        |          |               |        |                                     |         |
| Mother          |           |        |          |               |        |                                     |         |
| Brothers/Sister |           |        |          |               |        |                                     |         |
| Grandparents    |           |        |          |               |        |                                     |         |

**DOCTOR ONLY:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Current Medication or Supplements:** Please list the name, reason, and dosages, if possible. (Include all vitamins, herbal supplements, prescription and over-the-counter medications.)

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Allergies** (medication, food, other substance): Please list and state the reaction you had:

\_\_\_\_\_

**Date of your last physical exam / doctor visit:** \_\_\_\_/\_\_\_\_/\_\_\_\_ Results of exam: \_\_\_\_\_

**Date of your last cholesterol test:** \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_\_

| <b>Injuries/Surgeries:</b> | <b>Description</b> | <b>Date</b> |
|----------------------------|--------------------|-------------|
| Falls                      | _____              | _____       |
| Head Injuries              | _____              | _____       |
| Broken Bones               | _____              | _____       |
| Dislocations               | _____              | _____       |
| Motor Vehicle Collisions   | _____              | _____       |
| Surgeries                  | _____              | _____       |
| <i>Additional space:</i>   | _____              | _____       |
|                            | _____              | _____       |
|                            | _____              | _____       |

**Social History** (Please circle)

**Exercise:** None    Moderate    Daily    Heavy    Describe: \_\_\_\_\_

**Work Activity:** Sitting    Standing    Light Labor    Heavy Labor

**Stress Level:** Please rate your stress level on a scale of 0 (no stress) to 10 (Highly stressed)

0 1 2 3 4 5 6 7 8 9 10

**Tobacco Use:**

Previous Smoking:    Never    Previously- Date Quit: \_\_\_\_\_    Packs/Day \_\_\_\_    # of years \_\_\_\_

Current Smoking:    None    Packs/Day \_\_\_\_    # of years \_\_\_\_

Other:    \_\_Pipe    \_\_Cigar    \_\_Chew    \_\_Snuff

Are you interested in quitting?    Yes    No

**Alcohol Use:** Do you drink alcohol?    Yes    No    If so, how much? \_\_\_\_\_

**Caffeine Intake:**    \_\_None    \_\_Coffee/Tea \_\_\_\_cups/day    \_\_Pop or Soda \_\_\_\_/day    \_\_Chocolate \_\_\_\_oz./day

**Water Intake:** \_\_\_\_\_ oz. per day    **OR**    Number of 8oz. glasses per day \_\_\_\_\_

Patient Name: \_\_\_\_\_    Date: \_\_\_\_\_

