

Trump Chiropractic & Acupuncture | trumpchiro.com

PATIENT HISTORY

The following information is needed for our files so that we can better serve you as a patient. If you need any help, please ask the receptionist or your doctor.

Today's Date: _____ How did you hear about our clinic? _____

Is your visit due to a fall or accident? Yes/No Date of accident _____
Type of Accident or Fall (If applicable): _____ Location of Accident: _____

PERSONAL INFORMATION

Name: _____ Sex: _____ Age: _____
(First) (M.I.) (Last)
Social Security # _____ Home Phone: _____
Email address: _____
Address: _____ City: _____ State: _____
Marital Status: _____ Spouse's Name: _____ Number _____

EMPLOYER

Employer: _____ Years Employed: _____ Occupation: _____
Work Address: _____ Work Phone: _____
Did you or do you currently serve in the U.S. Military? Yes / No Do you have any injuries?
If yes, please explain: _____

INSURANCE INFORMATION

Name of Insurance Company: _____ Relationship to Patient: _____
List any additional insurances you may have: _____

HEALTH INFORMATION

Major Complaints: _____

Doctors seen, dates, and treatment received for above condition(s): _____

Date of last physical exam: _____ Doctor: _____
Date of last eye exam: _____ Doctor: _____

Please list any allergies you may have: _____

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List ALL Hospitalizations, Surgeries and Broken Bones:

Reason:	Hospital:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL Falls or Accidents (Auto or Other) Including those with Minor Injuries or

Date:	Incident:	Treatment, if any:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Habits:

Do you exercise regularly? Yes / No Type & frequency of exercise: _____

Do you use alcohol? Yes / No If so, how often? Daily / Weekly / Occasionally _____

Do you smoke tobacco? Yes / No If yes, how much? _____

Do you use illegal drugs? Yes / No _____

Women Only:

Age of Menstrual Onset: _____ Age of Menopause: _____ Date of Last Pe _____

List any menstrual difficulties or concerns: _____

Is there any chance you are currently pregnant? Yes / No _____

Number of Children: _____ Number of Pregnancies: _____

List any complications: _____

Type of Delivery: Cesarean / Vaginal / Premature / Full Term _____

Did you receive an epidural? Yes / No List any complications: _____

Any Miscarriages? Yes / No If yes, how many? _____

PERSONAL & FAMILY HISTORY

Do you or a family member currently suffer from any of the following conditions? (If yes, corresponding box. Write S next to those conditions you suffer from and F beside those suffers from.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy ^{3/4} |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression |

