TRAMONTIN WELLNESS CENTER

HELPING FAMILIES IMPROVE THE QUALITY OF THEIR LIVES WITH OPTIMAL HEALTH

Welcome to Tramontin Wellness Center
PLEASE PRINT THIS FORM, FILL IT OUT AND BRING IT WITH YOU ON YOUR FIRST VISIT.

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name____ Date_________ S/S____-____-_____

First MI Last

Address_________________________________City_____________State____Zip______

Sex: Female Male

Birth date__________________Home phone #___________Work phone #___________

E-mail address__________________(**Like us on Facebook at www.tramontinwellnesscenter.com**)

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

Your employer_____________________________Occupation_____________________

Business Address_______________________City____________State___Zip_________

Spouse's or parent's name_________________Workplace_____________Work phone#

Whom may we thank for referring you to us?____________________________________

Person to contact in case of emergency______________________Phone#____________

Name and Address of physician ____

____

Responsible Party

Name of person responsible for this account?_______________________S/S#__-__-__

Relationship to patient_____________________Phone #____________________

Address_________________________________City_____________State___Zip_____

Name of employer___________________________Work phone#__________________

Comprehensive History

Reason for visit________________________When did you first notice the symptoms?___________

What treatment have you already received for your condition?

Medication__________Surgery_______Physical Therapy_____Other___________

Name and Address of other doctor(s) who have treated you for your condition:__________________

____

Is this condition getting progressively worse?___________________________________

Where specifically is the problem(s) located?___________________________________

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Riding in a car Sitting at desk/computer Other____________________________

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other____

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?__________________________________

Does the pain radiate or refer to another area?__________________________________

Past History

General Health____

Childhood Illnesses: Polio Measles Mumps German Measles Chicken Pox

Adult Illnesses:____

Psychiatric Illnesses:____

Accidents and Injuries:____

Operations:____

Hospitalizations:____

Current Health Status

Do you have any allergies?____

Have you had immunizations: Hepatitis B Polio Measles Rubella Mumps Flu

Screening Tests: Last physical exam____________________Mammogram___________________

Cholesterol test_________results____________________

Tuberculin test______________________________Colinoscopy_____________________________

Do you live with or work with any environmental hazards?_________________________

Do you use your seat belts?_______________

Do you exercise?_______What type of exercise?_________________________________

How often do you exercise?____

Do you sleep well?_____________________________How many hours do you sleep?

____

Do you drink caffeine? Coffee_______tea________soda___________iced tea_________

Do you smoke?________How much?_________

Do you drink alcohol?________How much?______________

Do you use recreational drugs?____________How often?____________

Name: Date: Page 3.

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work, reaching, lifting)____

(Women) Are you pregnant? ________Nursing________Taking birth control pills______

List your current medications:____

____

List your current vitamins/herbs:____

____

Would you like Dr. Jackie to create a vitamin regimen designed to your specific needs/ according to your health history, and prevention of family history of disease?______________________________

Circle only those conditions which you have or have had:

AIDS/HIV, Cataracts, Hepatitis, Osteoporosis, Suicide Attempt, Alcoholism, Hernia, Pacemaker, Allergy shots, Herniated Disc, Tonsillitis, Anemia, Depression, Herpes, Pinched Nerve, Tuberculosis Anorexia, Diabetes, Pneumonia, Tumors, Growths, Appendicitis, Emphysema, Kidney disease, Polio Typhoid Fever, Arthritis, Epilepsy, Liver disease, Ulcers, Chemical dependency, Asthma, Fractures, Prosthesis, Glaucoma, Vaginal infections, Breast lump, Goite,r Miscarriage, Bronchitis, Gonorrhea, Bulimia, Gout, Scarlet fever, Cancer, Heart disease, Stroke, Parkinson’s disease, High cholesterol, Prostate problems, Migraine headaches, Psychiatric Care, Bleeding disorders, Mononucleosis,

Family History

Conditions of family members: Parents, siblings, spouse, children, grandparents (living or deceased)

Diabetes, Tuberculosis, Stroke, Cancer, High blood pressure,

Heart disease, Arthritis, Anemia, Headaches, Kidney disease,

Epilepsy, Alcoholism, Depression, High cholesterol, Mental illness,

Drug addiction

Review of Systems

Do you have skin problems?____

Do you wear glasses or contacts?____

Do you have any eye conditions?____

Do you have any hearing defects?____

Have you had ear infections?__________Ringing in the ears?_____________________

Have you had any sinus conditions?____

Have you had any problems with the following systems?

Neck Cardiac Breasts, Respiratory, Urinary Hormonal, Gastrointestinal, Genital Mouth and Throat