Trestman Chiropractic

Welcome to Trestman Chiropractic

Please tell us about yourself

Name: (Last) ______________________________ (First) ________________

Home Address: (st). ______________________ (city) __________________ (state) ______ (zip) _______

Home Phone Number: (______) ________________ Cell Phone: (______) ________________________

Email: ____

Birthdate: ______________ Age: ___________

Occupation: ____________________________

Emergency Contact: ___________________________ Phone Number: (______) ________________

Person responsible for this account: ____

Please provide us with the name and phone number of the person who referred you to our office so that we may thank them for their referral with a free adjustement:

Name: _________________________________ Phone number: ___________________________

PLEASE READ AND SIGN BELOW

I understand that all services rendered me are charged directly to me and I am personally responsible for payment ar the time of service.

Responsible Party Signature ________________________________ Date: ________________________

Symptom Survey

Name: ______________________ Date: _______________

Please circle all symptoms
you have EVER experienced

General Symptoms:
A) Nervousness F) PMS E) Fatigue
B) Depression G) Tension
C) Irritability H) Jaw Pain
D) Sleep Loss I) Anxiety

Head:
A) Headache 1) Mild 2) Moderate 3) Severe
B) Migraine
C) Vertigo/Dizziness
D) Light Headed E)Memory Loss F) Ringing in ears
G) Hearing Loss H)Blurred vision I)Loss of Balance
J) Double Vision K) Fainting L)Sensitivity to light

Neck:
A) Pain: 1) Left Side 2) Right Side 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Increased by:
1) Forward Movement 2) Backward Movement
3) Rotate Left 4) Rotate Right
5) Bend Left 6) Bend Right
B) Stiffness C) Muscle Spasm D) Grind/Grating Sounds

Shoulders:
A) Pain in joint 1) Left 2) Right 3) Both
B) Pain across shoulders 1) Left 2) Right 3) Both
C) Limitation of movement 1) Left 2) Right 3) Both
D) Tension 1) Left 2) Right 3) Both

Arms:
A) Pain in upper arm 1) Left 2) Right 3) Both
B) Pain in elbow 1) Left 2) Right 3) Both
C) Pain in forearm 1) Left 2) Right 3) Both
D) Pins & needles (arm) 1) Left 2) Right 3) Both
E) Pins & needles (forearm) 1) Left 2) Right 3) Both
F) Numbness in forearm 1) Left 2) Right 3) Both

Hands:
A) Pain in wrist 1) Left 2) Right 3) Both
B) Pain in hand 1) Left 2) Right 3) Both
C) Pins & needles 1) Left 2) Right 3) Both
D) Numbness 1) Left 2) Right 3) Both

Mid-Back:
A) Pain 1) Left 2) Right 3) Both
Pain level: 1) Mild 2) Moderate 3) Severe
Pain Type: 1) sharp/stabbing 2) Dull Ache
B) Spasm 1) Left 2) Right 3) Both

Chest:
A) Deep chest pain: 1) Left 2) Right 3) Both
B) Pain arounds ribs 1) Mild 2) Moderate 3) Severe
C) Shortness of breath
D) Irregular Heartbeat

Abdominal Symptoms:
A) Pain: 1) Mild 2) Moderate 3) Severe
B) Nervous Stomach C) Nausea D) Gas
E) Constipation F) Diarrhea G) Heartburn
H) Mentrual Cramps

Low-Back:
A) Upper Low-back pain: 1) Left 2) Right 3) Both
B) Lower Low-back pain: 1) Left 2) Right 3) Both
C) Sacro-illiac pain 1) Left 2) Right 3) Both
D) Muscle Spasm 1) Left 2) Right 3) Both
E) Low-back pain level 1) Mild 2) Moderate 3) Severe

Hips & Legs:
A) Pain in buttocks: 1) Left 2) Right 3) Both
Pain Level: 1) Mild 2) Moderate 3) Severe
B) Pain in hip joint 1) Left 2) Right 3) Both
Pain Level: 1) Mild 2) Moderate 3) Severe
C) Pain down leg: 1) Left 2) Right 3) Both
Location: 1) Left 2) Right 3) Both
D) Numbness down leg: 1) Left 2) Right 3) Both
Location: 1) Left 2) Right 3) Both
E) Pins & needles (leg) 1) Left 2) Right 3) Both
Location: 1) Left 2) Right 3) Both
F) Knee pain: 1) Left 2) Right 3) Both
G) Leg Cramps 1) Left 2) Right 3) Both

Feet:
A) Ankle Pain 1) Left 2) Right 3) Both
B) Swollen ankle 1) Left 2) Right 3) Both
C) Foot pain 1) Left 2) Right 3) Both
D) Numbness of feet 1) Left 2) Right 3) Both
E) Swollen feet 1) Left 2) Right 3) Both
F) Cramps 1) Left 2) Right 3) Both

Confidential
Patient Case History

Patient Name: ______________________________ Date: ____________

Was condition related to employement? ___ No ___Yes Date of Injury ____________

Was conditiona related to auto accident? ___ No ___Yes Date of Injury ____________

Check the Following Conditions You have Had

___Cancer	___ Stroke	___ Hepatitis	___ Measles
___Kidney Infection	___ Goiter	___ Polio	___ Mumps
___Diabetes	___ Anemia	___ Ulcer	___ Small Pox
___Heart Disease	___ Pneumonia	___ Alcoholism	___ Chicken Pox
___High Blood Pressure	___ Appendicitis	___ Mental/Emotional	___ Tuberculosis
___Sexual Disfunction	___ Incontinence		___ HIV/AIDS

Surgeries/Hospitalizationns:

______________ Year ________

______________ Year ________

______________ Year ________

______________ Year ________

Injuries/Fractures/Dislocations:

______________ Year ________

______________ Year ________

______________ Year ________

______________ Year ________

Lifestyle Habits:

Tobacco (Cigarettes/day) ____________ Coffee (cups/day) ____________ Sleep (hours/day) ________

Alcohol (drinks/day) ____________ Tea (cups/day) ____________ Soft drinks (cups/day) _____

Exercise: Type: ____________________ Frequency: ____________

(1 Drink = 1.5 oz. liquor, 12 oz. beer or 6 oz. wine)

Family Health History:

Relation Name Age Health Problems

Father____

Mother ____

Sister(s) ____

Brother(s) ____

Medication Taken Now: (prescription and nonprescription; include vitamins, supplements, etc.)

Name of medication Purpose Dosage How long taken?

____

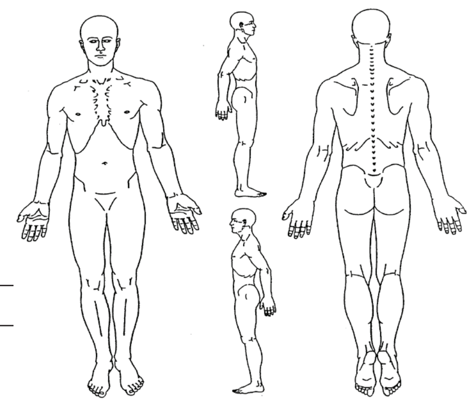
____

____

 Patient Name: ____________ Date: ________

Have you seen a chiropractor before? ___ Yes ___ No
If yes, Dr's Name ______________________ Date of Last Visit ________________

Have you ever been in a motor vehicle accident before?
_____ Past Year ____ Past five years ____ Over five years ____ Never



Mark an X on the picture where you have pain or discomfort.

History of Chief Complaint:

What is your major complaint? ______________________________

How long has this bothered you? ______________________________
When & how did this begin? (accident, injury, etc.)

Have you had this similar conditions in the past? ___ Yes ___ No
If yes, when ______________________________

When is your pain most severe?
___ Morning ___ Afternoon ___ Evening ___ Sleeping ___ All the time

What activities make your condition worse (please circle all that apply)
Standing Walking Sitting Lying Bending Lifting Twisting Coughing
Other: ______________________________

What activities make your condition better (please circle all that apply)
Medication Exercise Lying Standing Walking Bending Sitting
Other: ______________________________

List the doctors, therapist, etc. you have seen for this condition, dates, diagnostic test. treatments, etc.

Name	Date	Treatment	Better/Worse

Overall Frequency of complaint:
☐ Constant 100% of the time ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25%

List 3 goals you want to achieve through chiropractic care:

1. ____________ 2. ____________ 3. ____________