Chief Complaint

Name: ____ Date: ___________________

Describe your complaint/problem: ____

____

____

Is your condition due to an accident (Circle One)? No Auto Work Home Other __________

How long have you had this condition? ____

What seemed to be the initial cause? ____

Is it getting worse? Yes No

What makes the problem (feel) better? ____

What makes the problem (feel) worse? ____

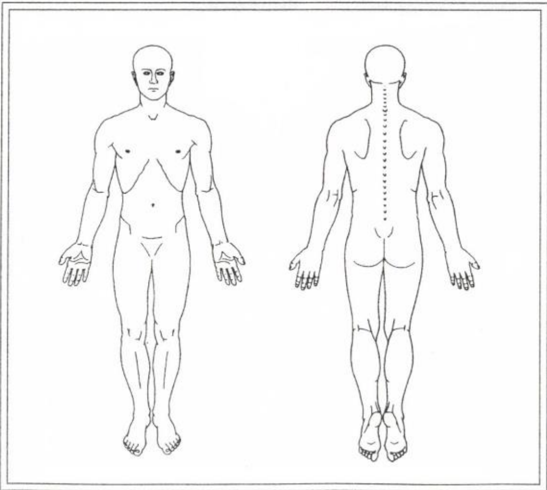
Have you been treated for this problem? _____ By whom? _________________________________

1) Shade the area where your pain occurs on the body diagram to the right.

2) Use the following scale to indicate your current pain in the areas you marked. Please write the number next to the areas you shaded.

0-10 Pain Scale:

0	No Pain
1-3	Mild
4-6	Moderate
7-9	Severe
10	Worst Possible



Please do not write in this area (LOCQSMAT):

____

____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

Name:____Preferred Language:________________

Family Medical History ***(List any diseases than run in your family and check the affected relative)***				
Diagnosis *Example: Heart Disease*	Father	Mother X	Sibling	Grandparent

Smoking Status: ☐Every Day Smoker ☐Occasional Smoker ☐Former Smoker ☐Never Smoked

Race: ☐American Indian ☐Alaska Native ☐Asian ☐Black/African American ☐Caucasian ☐Native Hawaiian ☐Pacific Islander ☐Decline to Answer

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e.5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit.** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:____Date:________________________

For office use only (highlight abnormal findings)

Age:_____Height:________Weight:________Blood Pressure:__________/__________Pulse:________Smoke: Y/N

Health History

Name: ____________________ Date: ____________

What is your occupation? ____________________ Do you enjoy your job? Yes No

Primary Care Physician: ____________________ **Clinic**: ____________________

Do you have a history of high blood pressure? Yes No

Do you exercise? Yes No If Yes, how much? ____________________

Circle any of the following conditions you have had or currently have:

Alcoholism
Allergies
Anemia
Aneurysm
Appendicitis
Arteriosclerosis
Arthritis
Articular derangements
Atrophy in the extremities
Bone weakening
Bowel movement changes/problems
Cancer
Chicken Pox
Cholera
Circulatory or cardiovascular disorder
Cold Sores
Congenital connective tissue disorder
Constipation
Degenerative joint disease
Diabetes

Diarrhea
Diphtheria
Disc degeneration
Eczema
Edema /Swelling Emphysema
Epilepsy
Fainting
Fatigue/Malaise, unexplained
Fever (current)
Flu (current)
Fracture or dislocation
Gout
Heart disease
Headaches
Herniated disc
High blood pressure
Infection (current)
Joint pain/anomaly
Loss of weight, unexplained
Malaria
Multiple sclerosis

Muscle weakness
Neurological disorder
Numbness
Osteoporosis Pacemaker
Painful menstruation
Pregnancy *If currently pregnant, due date:* ____________
Rectal bleeding
Scoliosis
Spinal canal stenosis
Spondylolisthesis
Stroke
Thyroid disease
Tingling
Tuberculosis
Vertebrobasilar insufficiency
Vertigo
Other ____________________
____
____
____
____

List any serious accidents, injuries or traumas in your life time: ____________________
____

List any serious health conditions, hospitalizations or surgeries you have had in your life time: ____________
____
____
____

TriNatural Healthcare

CHIROPRACTIC ACUPUNCTURE MASSAGE

"Try natural first..."

Registration Date: ____________________

Patient Name: ____
Last First Middle Initial Nickname if preferred

Address: ____
Street Apt # City State Zip

Date of Birth: ____________________

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other ____________ ☐ Decline

Do you consent to appointment reminders via: ☐ Text ☐ Email ☐ No

Please provide phone number(s) below for which we have permission to leave a voicemail.

Cell Phone: ____________________ Cell Phone Provider (i.e. AT&T) ____________________

Home/Other Phone: ____________________ E-mail Address: ____________________

May we send you an occasional health e-newsletter or specials? ☐ Yes ☐ No

Your Employer: ____________________ Marital Status: ____________________

Emergency Contact: ____________________ Phone: ____________ Relationship: ____________

How did you hear about our office? ______________________________

Insurance Information:

Health Insurance Co.: ______________________________

ID #: ____________________ Group #: ____________________

Name of Primary Person Insured: ____________________ Insured's Date of Birth: ____________________

Relationship to you: ____________________

Motor Vehicle and/or Personal Injury if Applicable:

Your Auto Insurance Company: ______________________________

PIP Claim Number: ____________________ Date of Injury: ____________ State Occurred ____________

Adjuster's Name: ____________________ Adjuster's Phone Number: ____________________

Attorney's Name: ____________________ Attorney's Phone Number: ____________________

Worker's Compensation Company: ______________________________

Claim Number: ____________________ Date of Injury: ____________ State Occurred ____________

Claim Manager's Name: ____________________ CM's Phone Number: ____________________

Attorney's Name: ____________________ Attorney's Phone Number: ____________________