Trimboli Chiropractic
648 Park Avenue
Huntington, New York 11743
(631) 421-4300

Please print Date _____

Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____
Email address_____
Best way to contact you? (home/cell/work phone/email/ text message)

Age _____ Date of Birth _____ Gender (M) (F)

Referred by _____

Occupation_____Employer _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes_____ No_____ (N/A)_____

If you have no symptoms or complaints, and are here for chiropractic maintenance care, please check here _____. *If you have a specific issue to address, please continue.*

Major complaints and symptoms — please be as specific as you can. _____
_____
_____
_____

How do you believe your problem/pain began? _____
_____
_____
_____
_____

When did you first notice this issue? _____

Have you lost any work? _____ (Date you last worked _____)

Have you ever had this condition before, or a similar condition? (Y/N)

Please describe (if applicable)_____
_____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever been treated by any doctor for this ailment?(Y/N)

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care_____

Will this be covered by any insurance? Major Medical _____ Auto ("no fault") _____
Workers' Compensation ____ Medicare _____ No Insurance_____
If you DO have insurance, and the policy is NOT under your name (for example, it's not through **your** employer), please specify if it is a SPOUSE (spouse date of birth _____) or PARENT (parent date of birth_____) who is the insured party.

Have you ever been in any accidents, (auto or otherwise), fall down stairs, fall from ladder, etc. (even as a child)? _____Please describe_____
_____

Are you allergic to anything that you are aware of? _____

Are you presently taking any medication, herbs, or over the counter products (aspirin included)? Yes_____ No_____

If yes, please name them:_____

Have you ever broken any bones? _____ Any dislocations? _____

What operations have you had? (N/A)_____Year _____
_____Year _____
_____Year _____

Have you ever had an X-Ray / MRI / CT ("cat scan") Y____N____
If so, what region? _____ Year_____

Have you had any surgery to replace hip, knee, etc.? _____Year _____

(if applicable) Do you have any reason to believe that you may be pregnant? Yes__No__

Do you have any health problems not listed above? _____

Do you wish to have a third person or chaperone present during your examination and treatment? Yes _____ No_____

Do you exercise regularly? Yes _____ No _____ What kind of exercise? _____

_____

Habits: (please check)

Tobacco Use _____ Caffeine _____Alcohol _____

Any hobbies ?_____

Have you been treated for any health condition by a physician in the past year? (Y/N)
If yes, for what condition? _____

Have you lost or gained weight (10 or more pounds) in the past year? (Y/N)

Use this space for any additional information you may wish to discuss _____

_____

_____

Have you had or do you now have any of the following symptoms **which are or have been of significant distress to you**? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now	**Past**		**Now**	**Past**
Headaches	____	____	Loss of Balance	____	____
Neck Pain	____	____	Fainting	____	____
Stiff Neck	____	____	Loss of Smell	____	____
Sleeping Problems	____	____	Loss of Taste	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Frequent Colds	____	____
Shoulder/Neck/Arm Pain	____	____	Stomach Upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
High Blood Pressure	____	____	Diabetes	____	____
Difficulty Urinating	____	____	Allergies	____	_____

Leg Cramps	____	____	Weakness in Arms	____	_____
Weakness in Legs	____	____	Gall Bladder	____	____
Shortness of Breath	____	____	Indigestion	____	____
Fatigue	____	____	Depression	____	____
Vomiting	____	____			
Lights Bother Eyes	____	____	Shoulder Pain	____	____
Loss of Memory	____	____	Swelling Joints	____	____
Ears Ring	____	____	Knee Pain	____	____
Face Flushed	____	____			
Menstrual Difficulties	____	____			

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

SIGNATURE _____

TODAY'S DATE _____