TRI-MED
HEALTH & WELLNESS CENTER, P.C.

Tri-Med Health & Wellness Center
3400 Dexter Court, Pavilion 1, Ste 105
Davenport, IA 52807
563-823-5555

CONFINDENTIAL HEALTH INFORMATION

Please allow are staff to photocopy your driver's license and insurance details. All information you supple is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date

Whom may we thank for referring you?

Age

Birthdate (MM/DD/YYYY)

Your First Name

Your Middle Initial

Your Last Name

Address City, State and Zip Code

Email Address

Cell Phone

Employer

Employer Address

Emergency Contact

Emergency Contact Relationship

Emergency Contact Phone Number

Have you consulted a Chiropractor Before?

- Yes
- No

If so, whom and when was your most recent visit?

What is the Reason for you visit today?

When did the symptoms begin?

Gender

- Female
- Male

Social Security #

Race

- American Indian
- Native Hawaiian
- Alaska Native
- Other Pacific Islander
- Asian
- Black Or African American
- Caucasian
- Other
- Decline to answer

Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Decline to specify

Smoking Status

- Never a Smoker
- Former Smoker
- Current Every Day Smoker
- Current Some Day Smoker
- Heavy Smoker
- Light Smoker

Marital Status

- Married
- Single
- Divorced
- Widowed
- Separated

Spouse's Name

Child's Name and Age

Child's Name and Age

Child's Name and Age

1. REVIEW OF SYSTEMS

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the circle beside any condition that you have **HAD** or currently **HAVE**.

a. MUSCULOSKELETAL

HAVE	HAD	
○	○	Osteoporosis
○	○	Hip pain
○	○	TMJ issues
○	○	Arthritis
○	○	Knee pain
○	○	Poor posture
○	○	Scoliosis
○	○	Foot/ankle pain
○	○	Neck pain
○	○	Shoulder pain
○	○	Back pain
○	○	Elbow/wrist pain

b. NEUROLOGICAL

HAVE	HAD	
○	○	Anxiety
○	○	Depression
○	○	Headache
○	○	Dizziness
○	○	Pins and needles
○	○	Numbness

c. CARDIOVASCULAR/RESPIRATORY

HAVE	HAD	
○	○	High blood pressure
○	○	Low blood pressure
○	○	High cholesterol
○	○	Poor circulation
○	○	Angina
○	○	Excessive bruising
○	○	Emphysema
○	○	Hay fever
○	○	Pneumonia
○	○	Apnea

d. DIGESTIVE/GASTROINTESTINAL

HAVE	HAD	
○	○	Anorexia/bulimia
○	○	Ulcer
○	○	Food sensitivities
○	○	Heartburn
○	○	Constipation
○	○	Diarrhea

e. SENSORY

HAVE	HAD	
○	○	Blurred vision
○	○	Ringing in ears
○	○	Hearing loss
○	○	Chronic ear infection
○	○	Loss of smell
○	○	Loss of taste

f. SKIN

HAVE	HAD	
○	○	Skin cancer
○	○	Psoriasis
○	○	Eczema
○	○	Acne
○	○	Hair loss
○	○	Rash

g. ENDOCRINE

HAVE	HAD	
○	○	Thyroid issues
○	○	Immune disorders
○	○	Hypoglycemia
○	○	Frequent infection
○	○	Swollen glands
○	○	Low energy

h. GENITOURINARY

HAVE	HAD	
○	○	Kidney stones
○	○	Infertility
○	○	Bedwetting
○	○	Prostate issues
○	○	Erectile dysfunction
○	○	PMS symptoms

i. CONSTITUTIONAL

HAVE	HAD	
○	○	Fainting
○	○	Low libido
○	○	Poor appetite
○	○	Fatigue
○	○	Sudden weight loss
○	○	Weakness
○	○	Sudden weight gain

2. **PERSONAL HEALTH HISTORY** (Please check the illnesses you have had in the past or have now)

HAD	HAVE		HAD	HAVE		HAD	HAVE	
○	○	AIDS/HIV	○	○	Glaucoma	○	○	Pacemaker
○	○	Alcoholism	○	○	Goiter	○	○	Parkinson's disease
○	○	Anemia	○	○	Gonorrhea	○	○	Pinched nerve
○	○	Appendicitis	○	○	Gout	○	○	Pneumonia
○	○	Arthritis	○	○	Heart Disease	○	○	Polio
○	○	Asthma	○	○	Hepatitis	○	○	Prostate problems
○	○	Bleeding disorders	○	○	Hernia	○	○	Prosthesis
○	○	Breast lump	○	○	Herniated disc	○	○	Psychiatric disorder
○	○	Bronchitis	○	○	Herpes	○	○	Rheumatoid arthritis
○	○	Bulimia	○	○	High cholesterol	○	○	Rheumatic fever
○	○	Cancer	○	○	Hypertension	○	○	Stroke
○	○	Cataracts	○	○	Kidney disease	○	○	Suicide attempt
○	○	Chemical Dependency	○	○	Liver disease	○	○	Thyroid problems
○	○	Chicken pox	○	○	Measles	○	○	Tonsillitis
○	○	Depression	○	○	Migraine headaches	○	○	Tuberculosis
○	○	Diabetes	○	○	Miscarriage	○	○	Tumors/growths
○	○	Emphysema	○	○	Mononucleosis	○	○	Ulcers
○	○	Epilepsy	○	○	Multiple sclerosis	○	○	Vaginal infections
○	○	Fibromyalgia	○	○	Mumps	○	○	Venereal disease
○	○	Fractures	○	○	Osteoporosis	○	○	Whooping cough

a. Have you had any unexplained weight changes in the last 6 months?
   - ○ Lost less than 10 pounds
   - ○ Gained more than 10 pounds
   - ○ No significant weight changes

b. Do you take medication? ○ Yes ○ No
   Please list any medications you're currently taking.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

c. Have you had any surgeries? ○ Yes ○ No
   Please list any surgeries you have had.

_____ _____
_____ _____
_____ _____
_____ _____

d. Do you have any allergies? ○ Yes ○ No
   Please list any allergies you have

_____ _____
_____ _____

e. Do you perform exercise on a daily basis?
   - ○ No daily exercise habits
   - ○ Mild exercise
   - ○ Moderate exercise
   - ○ Heavy exercise

3. FAMILY HEALTH HISTORY (Please check the illnesses your family has had in the past or have now)

HAD	HAVE		HAD	HAVE		HAD	HAVE	
○	○	AIDS/HIV	○	○	Epilepsy	○	○	Pacemaker
○	○	Alcoholism	○	○	Fibromyalgia	○	○	Parkinson's disease
○	○	Anemia	○	○	Glaucoma	○	○	Psychiatric disorder
○	○	Arthritis	○	○	Gout	○	○	Rheumatoid arthritis
○	○	Asthma	○	○	Heart Disease	○	○	Seizures
○	○	Bleeding disorders	○	○	Hepatitis	○	○	Stroke
○	○	Bronchitis	○	○	High cholesterol	○	○	Suicide attempt
○	○	Bulimia	○	○	Hypertension	○	○	Thyroid problems
○	○	Cancer	○	○	Immune deficiency	○	○	Tuberculosis
○	○	Chemical Dependency	○	○	Kidney disease	○	○	Tumors/growths
○	○	Depression	○	○	Liver disease	○	○	Ulcer
○	○	Diabetes	○	○	Multiple sclerosis			
○	○	Emphysema	○	○	Osteoporosis			

f. Which family member(s) suffer from these condition(s)?

_____

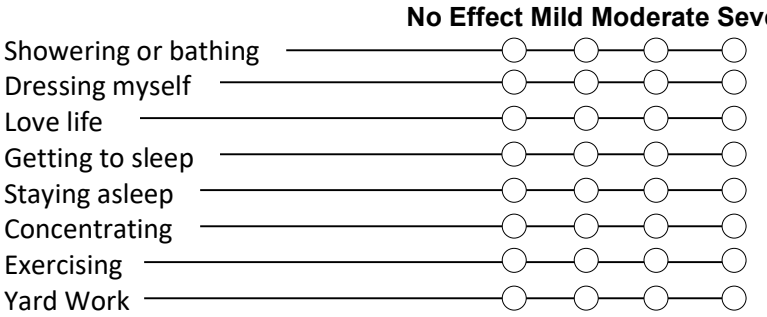
4. SOCIAL HISTORY

Alcohol use	○ Daily	○ Frequently	○ Weekly	○ Occasionally	○ Never
Coffee use	○ Daily	○ Frequently	○ Weekly	○ Occasionally	○ Never
Tobacco use	○ Daily	○ Frequently	○ Weekly	○ Occasionally	○ Never
Exercise	○ None	○ Daily	○ Weekly	○ Occasionally	○ Never
Pain relievers	○ Daily	○ Frequently	○ Weekly	○ Occasionally	○ Never
Soft drink	○ Daily	○ Frequently	○ Weekly	○ Occasionally	○ Never
Water intake	○ Daily	○ 0-32oz	○ 33-64oz	○ 65-80oz	○ 81+oz

Prayer or meditation?	○ Yes	○ No
Job pressures/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No

5. ACTIVITIES OF DAILY LIVING

	No Effect	Mild	Moderate	Severe
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of a car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○



g. What is the major stressor in your life? _____
h. How much sleep do you average per night? _____
i. What is the approximate age of your mattress and pillow? _____
j. What is your preferred sleeping position? _____
k. Describe your typical eating habits:
   ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals
l. What would be the most significant thing that you could do to improve your health? _____
m. In addition to the main reason for your visit today, what additional health goals do you have?
   _____

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from and involved third parties.

Initials_____ realize that an x-ray examination may be hazardous to an unborn child and certify that to the)est of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):

Initials_____ I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____
Signature of Patient/Parent or Guardian *Date (MM/DD)/YYYY)*

_____
Printed name of Patient/Parent or Guardian