

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

Please fill out the following form in as much detail as possible.

*Please print*

Date \_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Email address \_\_\_\_\_

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? \_\_\_\_\_

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When did you first notice this problem/pain? \_\_\_\_\_

Have you lost any work? \_\_\_\_\_ Day and date you last worked \_\_\_\_\_

Have you ever had this condition before or a similar condition? \_\_\_\_\_

When? Please describe (if applicable) \_\_\_\_\_

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What positions or activities aggravate your condition? \_\_\_\_\_

What positions or activities relieve your condition? \_\_\_\_\_

Have you ever been treated by a doctor for this ailment? \_\_\_\_\_

Describe the type of treatment \_\_\_\_\_

Diagnosis of previous physician \_\_\_\_\_

Length of time under care \_\_\_\_\_

Will this case be covered by any insurance company? Major Medical \_\_\_\_\_ Auto \_\_\_\_\_  
Workers' Compensation \_\_\_\_\_ Medicare \_\_\_\_\_ No Insurance \_\_\_\_\_

Have you ever been in any accidents, (auto or otherwise), fall down stairs, fall from ladder, etc. (even as a child)? \_\_\_\_\_ Please describe \_\_\_\_\_

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Are you allergic to anything you are aware of? \_\_\_\_\_

Are you presently taking any medication, herbs, or over the counter products (aspirin included)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name them

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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”) of your neck or back? 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? Y \_\_\_ N \_\_\_

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 \_\_\_\_\_

Hobbies

\_\_\_\_\_

Have you been treated for any health condition by a physician in the past year? \_\_\_\_\_  
 If yes, what condition?

\_\_\_\_\_

Have you lost or gained weight in the past year? \_\_\_\_\_

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.

	<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>
	<b>N</b>	<b>P</b>		<b>N</b>	<b>P</b>
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	_____	_____	Buzzing in Ears	_____	_____
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.

PATIENT SIGNATURE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE \_\_\_\_\_