



Welcome to Tramontin Wellness Center

PLEASE PRINT THIS FORM, FILL IT OUT AND BRING IT WITH YOU ON YOUR FIRST VISIT.

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ S/S _____ - _____ - _____

First MI Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male

Birth date _____ Home phone # _____ Work phone # _____

E-mail address _____ (To receive our informative newsletter)

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone# _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone# _____

Name and Address of physician _____

Responsible Party

Name of person responsible for this account? _____ S/S# _____ - _____ - _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone# _____

Can we contact you on facebook? Yes No



Comprehensive History

Reason for visit _____ When did you first notice the symptoms? _____

What treatment have you already received for your condition?

Medication _____ Surgery _____ Physical Therapy _____ Other _____

Name and Address of other doctor(s) who have treated you for your condition: _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Riding in a car Sitting at desk/computer Other _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other _____

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

Does the pain radiate or refer to another area? _____

Past History

General Health _____

Childhood Illnesses: Polio Measles Mumps German Measles Chicken Pox

Adult Illnesses: _____

Psychiatric Illnesses: _____

Accidents and Injuries: _____

Operations: _____

Hospitalizations: _____

Current Health Status

Do you have any allergies? _____

Have you had immunizations: Hepatitis B Polio Measles Rubella Mumps Flu

Screening Tests: Last physical exam _____ Mammogram _____

Cholesterol test _____ results _____

Tuberculin test _____ Colonoscopy _____



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Do you live with or work with any environmental hazards? _____

Do you use your seat belts? _____

Do you exercise? _____ What type of exercise? _____

How often do you exercise? _____

Do you sleep well? _____ How many hours do you sleep?

Do you drink caffeine? Coffee _____ tea _____ soda _____ iced tea _____

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Do you use recreational drugs? _____ How often? _____

Name: _____

Date: Page 3.

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work, reaching, lifting) _____

(Women) Are you pregnant? _____ Nursing _____ Taking birth control pills _____

List your current medications: _____

List your current vitamins/herbs: _____

Would you like Dr. Jackie to create a vitamin regimen designed to your specific needs/ according to your health history, and prevention of family history of disease? _____

Circle only those conditions which you have or have had:

AIDS/HIV, Cataracts, Hepatitis, Osteoporosis, Suicide Attempt, Alcoholism, Hernia, Pacemaker, Allergy shots, Herniated Disc, Tonsillitis, Anemia, Depression, Herpes, Pinched Nerve, Tuberculosis, Anorexia, Diabetes, Pneumonia, Tumors, Growths, Appendicitis, Emphysema, Kidney disease, Polio, Typhoid Fever, Arthritis, Epilepsy, Liver disease, Ulcers, Chemical dependency, Asthma, Fractures, Prosthesis, Glaucoma, Vaginal infections, Breast lump, Goiter, Miscarriage, Bronchitis, Gonorrhea, Bulimia, Gout, Scarlet fever, Cancer, Heart disease, Stroke, Parkinson's disease, High cholesterol, Prostate problems, Migraine headaches, Psychiatric Care, Bleeding disorders, Mononucleosis,



Family History

Conditions of family members: Parents, siblings, spouse, children, grandparents (living or deceased)
Diabetes, Tuberculosis, Stroke, Cancer, High blood pressure,
Heart disease, Arthritis, Anemia, Headaches, Kidney disease,
Epilepsy, Alcoholism, Depression, High cholesterol, Mental illness,
Drug addiction

Review of Systems

Do you have skin problems? _____

Do you wear glasses or contacts? _____

Do you have any eye conditions? _____

Do you have any hearing defects? _____

Have you had ear infections? _____ Ringing in the ears? _____

Have you had any sinus conditions? _____

Have you had any problems with the following systems?

Neck Cardiac Breasts, Respiratory, Urinary Hormonal, Gastrointestinal, Genital Mouth and Throat