TRUSALUS
YOUR TRUHEALTH CENTER

PATIENT INFORMATION

Name _____Date_____

Specific Problems_____

Address _____

City _____State_____Zip_____

Home Phone_____ Cell Phone _____

Social Security # _____-____-_____ E-mail _____

Date of Birth ____/____/_____ Martial Status: M S W D How many children:____

Spouse's Name_____ Phone _____

Emergency Contact_____ Phone _____

Primary Physician_____ Phone _____

How did you hear about us?

□ Forward Motion □ Yelp □ FORMA Gym

□ Dr. Referral □ Current Promotion_____

Who referred you? _____

Is this complaint due to:

□ Auto Accident □ Work Related Other_____

_____ _____

Patient Signature **Date**

_____ _____

Responsible Party Signature **Date**

If you have ever experienced a condition in your past, please check past.
If you are currently experiencing a condition, please check present.

Past ☐ ☐ Present

MUSCULO-SKELETAL

- ☐ ☐ Low Back Pain
- ☐ ☐ Pain Between Shoulders
- ☐ ☐ Neck Pain
- ☐ ☐ Arm Pain
- ☐ ☐ Joint Pain/Stiffness
- ☐ ☐ Walking Problems
- ☐ ☐ Difficulty Chewing/Clicking Jaw

NERVOUS SYSTEM

- ☐ ☐ Numbness
- ☐ ☐ Paralysis
- ☐ ☐ Dizziness
- ☐ ☐ Forgetfulness
- ☐ ☐ Confusion/Depression
- ☐ ☐ Fainting
- ☐ ☐ Convulsions
- ☐ ☐ Cold/Tingling Extremities
- ☐ ☐ Changes in Handwriting
- ☐ ☐ Irritability
- ☐ ☐ Changes in Personality

GENERAL

- ☐ ☐ Allergies
- ☐ ☐ Loss of Sleep
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Headache

GASTRO-INTESTINAL

- ☐ ☐ Poor/Excessive Appetite
- ☐ ☐ Excessive Thirst
- ☐ ☐ Frequent Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver Trouble
- ☐ ☐ Gall Bladder Problems
- ☐ ☐ Weight Trouble
- ☐ ☐ Abdominal Cramps
- ☐ ☐ Gas/Bloating After Meals
- ☐ ☐ Heartburn
- ☐ ☐ Black/Bloody Stool
- ☐ ☐ Colitis

GENITO-URINARY

- ☐ ☐ Bladder Trouble
- ☐ ☐ Painful/Excessive Urination
- ☐ ☐ Discolored Urine

C-V-R

- ☐ ☐ Chest Pain
- ☐ ☐ Shortness of Breath
- ☐ ☐ Blood Pressure Problems
- ☐ ☐ Irregular Heartbeat
- ☐ ☐ Heart Problems
- ☐ ☐ Lung Problems/Congestion
- ☐ ☐ Varicose Veins
- ☐ ☐ Ankle Swelling

EENT

- ☐ ☐ Vision Problems
- ☐ ☐ Dental Problems
- ☐ ☐ Sore Throat
- ☐ ☐ Ear Aches
- ☐ ☐ Hearing Difficulty
- ☐ ☐ Stuffed Nose

MALE/FEMALE CODE

- ☐ ☐ Menstrual Irregularity
- ☐ ☐ Menstrual Cramping
- ☐ ☐ Vaginal Pain/Infections
- ☐ ☐ Breast Pain/Lumps
- ☐ ☐ Prostate/Sexual Dysfunction
- ☐ ☐ Genital Herpes
- ☐ ☐ Menopause

FAMILY HISTORY:

Mother: ☐Cancer ☐Diabetes ☐Heart ☐High Blood Pressure ☐Respiratory Problems ☐Kidney ☐Stroke ☐In Good Health
If Deceased-Age at Death _____

Father: ☐Cancer ☐Diabetes ☐Heart ☐High Blood Pressure ☐Respiratory Problems ☐Kidney ☐Stroke ☐In Good Health
If Deceased-Age at Death _____

Siblings: ☐Cancer ☐Diabetes ☐Heart ☐High Blood Pressure ☐Respiratory Problems ☐Kidney ☐Stroke ☐In Good Health
If Deceased-Age at Death _____

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Number of Children: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐None

Do You: ☐Exercise Regularly ☐Eat a Balanced Diet ☐Obtain Sufficient Rest

Indicate your level of Exercise ☐Regularly ☐Weekend Warrior ☐Professional Athlete ☐Athlete in Training ☐None

Do You Smoke: ☐No ☐Less than 1 ☐1-2 ☐2-3 ☐3-4 ☐More than 5 (packs/day)

Do You Drink Coffee/Tea: ☐No ☐Occasionally ☐1-2 ☐2-3 ☐3-4 ☐More than 5 (cups/day)

Do You Drink Alcohol: ☐No ☐Occasionally ☐1-2 ☐2-3 ☐3-4 ☐More than 5 (drinks/day)

OCCUPATIONAL HISTORY:

Nature of Work _____

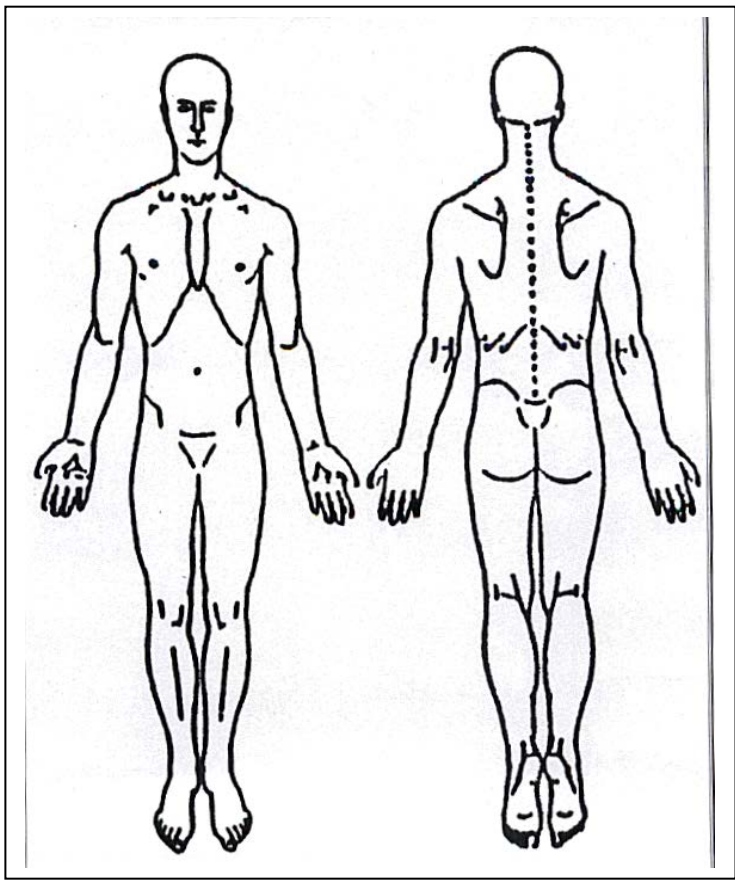
Primary Positions Required: ☐Sitting ☐Standing ☐Walking ☐Driving ☐Other _____

Repetitive Activities _____

Dr's Notes: _____

On the Diagram at the right, please indicate where you are experiencing pain right now. (Please mark the exact location of your pain on the diagrams using the abbreviations listed below.)

Pain = **P**
Tingling = **T**
Numbness = **N**
Burning = **B**
Stiffness = **S**



Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Hepatitis
- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbar
- ☐ Eczema

List any serious illnesses you have had that are not listed above: _____

_____

List any birth defects: _____

_____

List any hospitalizations and surgeries: _____

_____

List any injuries for which you were not hospitalized: _____

_____

MEDICATIONS:
List all medications that you are currently taking or have taken on a regular basis in th elast 6 months (include home remedies).

_____ _____

_____ _____

_____ _____

MEDICATIONS TO WHICH YOU ARE ALLERGIC:

_____ _____

_____ _____