NEW PATIENT INFORMATION

Client# ____________ Today's Date:__________

PLEASE PRINT CLEARLY

Full Name:---------------- E-mail: ----------------

Address: ---------------------------- City: ------State:____ Zip:______

Home pH: (__)______Work Phone: (__)________ Cell pH (__)__________

Gender M / F Soc Security#--------- Birth Date:_______ Age: ___

Marital Status S / M / D / W #of Children ________ #of Siblings______ #ofOlder ______ #of Younger______

Work Status: D Full Time D Part Time O Retired D Not Employed

Females: Last Menstrual Period:-------- Pregnant Y/N Nursing Y/N

Employer:---------- Occupation: -----------

In case of Emergency contact:------------------ Relationship: -----------

Emergency contact phone# (..._____, ------------- Name of Spouse/Parent/Guardian ---------

How did you hear about Dr. David Trybus? Whom may we thank for referring you? ____________________

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care procedures we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1.The patient understands and agrees to allow the Dr. Trybus to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.

2.The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.

3.A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4.The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5.For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Mladenoff Clinic to assure that your records are not readily available to those who do not need them.

6.If a patients has a complaint about the privacy of records please contact Dr. Trybus

7.If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________ __________

Signature Date

HEALTH CONCERNS: **Please list your top health concerns in order of priority.**

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

5) ______________________________

TREATMENT: **What type of treatment are you looking for?**

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problems and then go on to "achieve optimal health and wellness".

COMPLAINT/PROBLEM: **In relation to your primary condition:**

When did you first seek treatment for this problem? ______________

Has another doctor(s) treated you for this condition ☐Y ☐N If yes whom? __________ Treatment(s): __________

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: ______________

If this is a recurrence, when was the first time you noticed this problem? ______________

How did it originally occur? ______________

Has it become worse recently ? ☐Y ☐N ☐Same ☐Better ☐Gradually Worse

How frequent is this condition? ☐Constant ☐daily ☐Intermittent ☐Night Only

How long does it last? ☐All Day ☐A few Hours ☐Minutes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily ☐Routine ☐ Recreation ☐Other: __________

How long has it been since you really felt good? ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ > 10 years

Describe the pain: ☐Sharp ☐Dull Numbness ☐Tingling ☐Aching ☐Burning ☐ Stabbing ☐Other __________

What makes the problem worse:? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Testing ☐Other ______

Is there anything you can do to relieve the problem? ☐Y ☐N Describer: ______________

If no, what have you tried that has not helped? ______________

What do you believe is wrong with you? ______________

Are there any other conditions/symptoms related to your major symptom? ☐Y ☐N If yes, what? __________

Have you been in an auto accident? ☐Never ☐Past year ☐Past 5 years ☐Over 5 years

Describe: ______________

Please check all of the symptoms that apply: (P=Past / C = Current)

P / C		P / C		P / C	
☐ ☐	Headache	☐ ☐	High Blood Pressure	☐ ☐	Tingling in feet
☐ ☐	Facial Pain	☐ ☐	Low Blood Pressure	☐ ☐	Walking problems
☐ ☐	Eye Pain	☐ ☐	Abdominal Pains	☐ ☐	Sore muscles
☐ ☐	Blurred Vision	☐ ☐	Nausea/Vomiting	☐ ☐	Weak muscles
☐ ☐	Dizziness	☐ ☐	Poor Appetite	☐ ☐	Paralysis
☐ ☐	Earache	☐ ☐	Fullness of Bladder	☐ ☐	Shakiness
☐ ☐	Forgetfulness	☐ ☐	Urinary Difficulty	☐ ☐	Sweating
☐ ☐	Confusion	☐ ☐	Frequent Urination	☐ ☐	Insomnia
☐ ☐	Sinusitis	☐ ☐	Constipation	☐ ☐	Fainting
☐ ☐	Teeth Grinding	☐ ☐	Hemorrhoids	☐ ☐	Convulsions
☐ ☐	Dry Mouth	☐ ☐	Decreased Sex Drive	☐ ☐	Irritability
☐ ☐	Excessive Thirst	☐ ☐	Menstrual Irregularities	☐ ☐	Impatience
☐ ☐	Unpleasant Taste	☐ ☐	Elbow / Hand pain	☐ ☐	Fatigue
☐ ☐	Neck Pain	☐ ☐	Tingling in Hands	☐ ☐	Feel loss of control
☐ ☐	Sore Throat	☐ ☐	Clammy Hands	☐ ☐	Other __________
☐ ☐	Lump in Throat	☐ ☐	Low Back Pain		__________
☐ ☐	Swallowing Pain	☐ ☐	Hip Pain		
☐ ☐	Unsteady Voice	☐ ☐	Knee Pain		
☐ ☐	Shoulder Pain	☐ ☐	Poor Circulation		
☐ ☐	Persistent Cough	☐ ☐	Swollen Joints		
☐ ☐	Chest Pressure	☐ ☐	Joint Stiffness		
☐ ☐	Slow Heart Rate	☐ ☐	Swollen Ankles		
☐ ☐	Rapid Heart Rate	☐ ☐	Ankle / Foot Pain		

List and describer the problems you are having and draw them on the chart below.

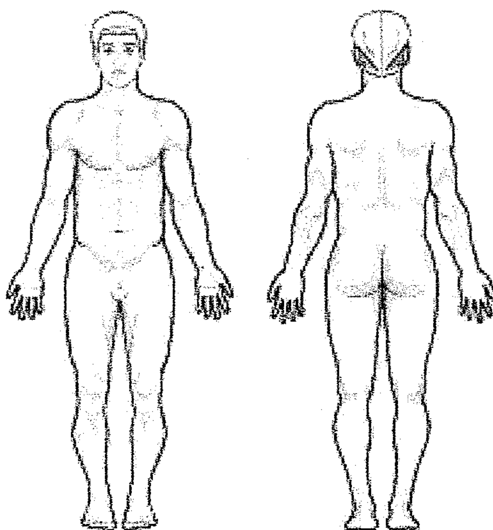
1. ____

2. ____

3. ____

4. ____.

5. ____.



GRADE YOUR PAIN
1 (= none) to 10 (= very severe)

PROBLEM #	GRADE
1	1 2 3 4 5 6 7 8 9 10
2	1 2 3 4 5 6 7 8 9 10
3	1 2 3 4 5 6 7 8 9 10
4	1 2 3 4 5 6 7 8 9 10
5	1 2 3 4 5 6 7 8 9 10

ALLERGIES: Please check and list all allergies.

☐ Food: ____________________
☐ Seasonal: ____________________
☐ Environmental: ____________________
☐ Medications____________________

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Drug Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Arthritis Drugs		
☐ Behavioral Modification Drugs		
☐ Blood Pressure Lowering Drugs		
☐ Cholesterol Lowering Drugs		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

Scars/Surgical Procedures: List all scars and surgeries ____________________

____

Supplements: Do you take Vitamins/Supplements Herbs/Homeopathics? If yes, who recommended them?

____

HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda Pop	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	Type	Time
Exercise	☐	☐	☐	________	________

	8+ Hrs	7-8 Hrs	6-7 Hrs	5-6 Hrs	<5 Hrs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2	1
Meals	☐	☐	☐	☐	☐

	64+ oz	32-64oz	16-32oz	< 8 oz
Water	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking/Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past: (G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

___Alcoholism/Drug Abuse
___Anemia
___Cancer
___Cold Sores
___Deep Vein Thrombosis
___Detached Retina
___Diabetes
___Diverticulitis / IBS

___Eczema
___Emphysema
___Epilepsy
___Goitre
___Gout
___Heart Disease
___Hepatitis
___HIV / ADIS

___Miscarriage(s)
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic Fever
___Seizures/Fainting
___Stroke

___Tumor(s)
___Ulcers
___Vaccine reaction
___Other: ____________________
____
____

____
Patient's Name (Printed)

____
Patient Signature

____
Date: