# TRULL CHIROPRACTIC, P.A.

www.TrullChiro.com

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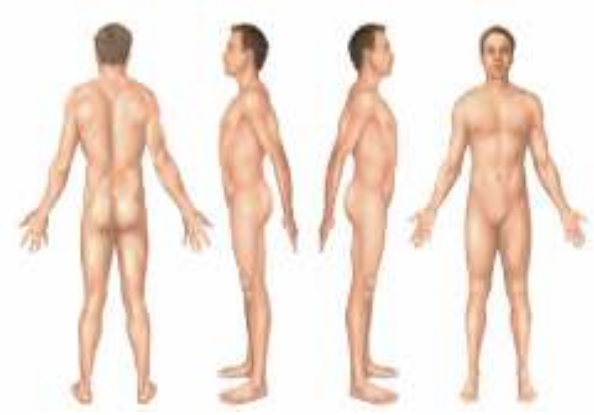
**Date: _____ Name: _____ Birth date: _____**

**Please indicate on the body diagram to the right where you are experiencing symptoms.**



Describe your symptoms: _____

_____

When did your symptoms start? _____ / _____ / _____

How did your symptoms begin? _____

_____

_____

**How often do you experience your symptoms?**

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

**What describes the nature of your symptoms?**

☐ Sharp ☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Tingling ☐ Stabbing ☐ Numbness

**Since your symptoms began, indicate the average intensity of your symptoms on a 0-10 scale (where "0" is no pain and "10" is unbearable pain): _____**

**What aggravates your symptoms:**

☐ sit ☐ stand ☐ walk ☐ bend ☐ stoop ☐ lift ☐ sleep
☐ sneeze ☐ cough ☐ strain ☐ reach ☐ twist ☐ look up ☐ look down
☐ exercise ☐ rest ☐ lying flat ☐ driving ☐ typing ☐ scoop ☐ movement
☐ stairs ☐ household chores

**What relieves your symptoms:**

☐ sit ☐ stand ☐ lying ☐ knees bent up ☐ support
☐ movement ☐ no movement ☐ heat ☐ ice ☐ analgesic topical
☐ ibuprofen ☐ medication ☐ rest ☐ adjustments ☐ stretching/exercise

**Who have you seen for your symptoms?**

☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
☐ Other: _____

**What treatment did you receive for your symptoms?**

☐ Adjustments ☐ Physical Therapy ☐ Medication ☐ Other: _____

**What tests have you had for your symptoms?**

☐ X-rays ☐ MRI ☐ CT Scan ☐ Other: _____

**When were these tests done?**

☐ 1 week or less ☐ 1 month or less ☐ 6 months or less ☐ 6 months or more

**Have you had similar symptoms before?** ☐ **No** ☐ **Yes** (specify below)

☐ This office ☐ Other Chiropractor ☐ Medical doctor ☐ Physical therapist
☐ Other: _____

## If your symptoms are the result of an accident, please complete the following:

Please check: ❑ automobile ❑ work comp ❑ personal injury ❑ fall
❑ other: _____

Date of accident: _____ Time: _____

Place of accident: _____

Describe how the accident occurred: _____

_____

_____

_____

**Have you seen another doctor for these injuries?** ❑ yes ❑ no

If so, please give doctor's name:_____

When were you seen?_____

**Were you treated in the emergency room/Quick Care?** ❑ yes ❑ no **X-rayed?** ❑ yes ❑ no

If so, which hospital? _____

When were you seen? _____

**Additional questions for automobile-related accidents:**

| | | |
|---|---|---|
| Were you wearing your seatbelt? | ❑ yes | ❑ no |
| Did the airbags deploy? | ❑ yes | ❑ no |
| Where were you in the vehicle? | ❑ driver<br>❑ pedestrian | ❑ passenger (front seat)<br>❑ passenger (back seat) |
| Check all parties involved in MVA: | ❑ single vehicle<br>❑ pedestrian<br>❑ bicycle<br>❑ other: _____ | ❑ multiple vehicles (#: ____ )<br>❑ animal<br>❑ stationary structure/vehicle |
| What type of vehicle were you in? | ❑ car<br>❑ motorcycle | ❑ SUV ❑ pickup truck<br>❑ other:_____ |
| What was the other vehicle involved? | ❑ car<br>❑ motorcycle | ❑ SUV ❑ pickup truck<br>❑ other:_____ |

Were there additional parties (i.e., pedestrians, animals, non-motorized vehicle, etc.)?

List: _____

**If these injuries were the result of an automobile accident, please provide our office with a copy of the police report, as well as the appropriate insurance information.**

**If these injuries were the result of a work comp accident, we will need authorization from your employer and/or their work comp insurance carrier in order to file your charges.**