layôs Date_____ Phone_____

_____City_____ State____ Zip_____

Date of Birth _____/_____/_____ Age ____ Marital status____ Number of children____

Occupation_____ Spouse_____ Email_____

Referred by_____

Major Complaint_____

Started when_____ What do believe is wrong_____

Is it getting better /worse /not changing_____

What makes it worse_____ What makes it better_____

Is it interfering with your sleep, appetite, daily routine_____

How old is your mattress_____ Do you sleep on your side/back /stomach_____

Do you wear arch supports_____ I go to the dentist every _____ I exercise _____ week

My Fatherôs Health_____

My motherôs Health_____

Sibling's health_____

List any surgeries or hospital visits_____

Last time I had a spinal exam _____Doctor_____ Why_____

Physical Exam _____ Doctor_____ Why_____

X-ray_____ Blood work_____ Why_____

I drink _____ glasses of water per day, I drink alcohol _____ week, I drink coffee_____ week

My sleep is _____ quality and when I wake up I feel_____ I sleep for _____Hours

My appetite is _____ I defecate how often_____ my pee is what color_____

I wake up _____ times per night

Place an N for **n**ow, P for **p**ast leave blank it does not apply

- ❑ Headache
- ❑ Loss of sleep
- ❑ Nervousness
- ❑ Depression
- ❑ Numbness
- ❑ Sweats
- ❑ Tremors
- ❑ Arthritis
- ❑ Foot trouble

Pain, numbness or stiffness in:

- ❑ Low back
- ❑ Mid-back
- ❑ Neck pain
- ❑ Shoulders
- ❑ Arms
- ❑ Elbow
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet
- ❑ Swollen joints
- ❑ Belching
- ❑ Gas
- ❑ Difficult digestion
- ❑ Distension of abdomen
- ❑ Excessive hunger
- ❑ Gallbladder trouble
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Nausea
- ❑ Pain over stomach
- ❑ Vomiting
- ❑ Asthma
- ❑ Colds
- ❑ Deafness
- ❑ Dental decay
- ❑ Ear noises
- ❑ Eye pain
- ❑ Failing vision
- ❑ Gum trouble
- ❑ Nosebleeds
- ❑ Nasal obstruction
- ❑ Sinus infection
- ❑ Sore throat
- ❑ Blood pressure
  - ○ Low
  - ○ High
- ❑ Pain over heart
- ❑ Rapid heart beat
- ❑ Poor circulation
- ❑ Chronic cough
- ❑ Difficult breathing
- ❑ Spiting up phlegm
- ❑ Spitting up blood
- ❑ Boils
- ❑ Bruise easily
- ❑ Dry skin
- ❑ Itchy skin
- ❑ Inability to control kidneys
- ❑ Kidney stones or infection
- ❑ Painful urination
- ❑ Prostrate trouble
- ❑ Anemia
- ❑ Cancer
- ❑ Cold sores
- ❑ Diabetes
- ❑ Gout
- ❑ Stroke

For women only

- ❑ Irregular cycle
- ❑ Congested breasts
- ❑ Cramps
- ❑ Backache
- ❑ Hot flashes
- ❑ Painful Menstruation
- ❑ Vaginal Discharge
- ❑ Miscarriage

I take the following supplements

_____

_____

I take the following medications_____

_____

_____

estman D.C. , C.C.S.P.

11
Tr

Phone 530-550-1688
Fax 530-550-1622

____/____/____

Dear Patient,

Please give us 24 hour notice to change an appointment. If you do not we are forced to charge you a 95.00 fee that is not reimbursable through insurance.

Thank you,

Barry Triestman D.C.

Patient Name_____

Patient Signature_____

Also, we need to inform you that your insurance plan will not pay for Active Release Technique, Graston Technique, gait analysis, Pilates and nutritional consultations. They are non-covered services and there will be additional charges for these. They will pay for chiropractic care and examinations. As your agreement allows.

Active Release Techniques 95.00

Nutritional Consultations 95.00

Analyze blood work 50.00

Pilates 75.00

Patient Signature_____

ENT INFORMED CONSENT

_____
Patient's Name

Barry Triestman D.C. _____ has explained to me:

1. The general treatment or procedure Spinal manipulation

_____; and

2. There may be other procedures or methods of treatment; and

3. There are risks to the treatment or procedure proposed.

The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any more information. **I give my permission and consent to the treatment or procedure.**

x_____ _____
Patient's Signature Date

SIGN IN THIS BOX ONLY IF YOU REQUESTED
AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, a further explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment. **I give my permission and consent to the treatment or procedure**.

x_____ _____
Patient's Signature Date

I explained the procedures, alternatives, and risks in conference with the patient.

x_____ _____
Doctor's Signature Date