Dr. Nancy Trimboli · 12732 Wicker Ave · Cedar Lake, IN 46303 · 219-374-4144

New Patient Form

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept you case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and to its entirety.

Name:_____ Nickname: _____ **Contact Information:**

SSN:_____Age:_____ Birth Date: _____ Email: _____

Address: _____ Cell #: _____

City, State, Zip_____Martial Status: S M W D Children:_____ Home #:_____

Occupation:_____Employer:_____Office Phone: _____

Work Address:_____City:_____State:_____Zip: _____

Name of Wife/Husband/Parents:_____Occupation:_____

Employer:_____Office Phone:_____

In case of emergency, contact:_____Phone: _____

How did you hear about us? _____

List present complaints, injuries and duration.

1._____

_____

_____

2._____

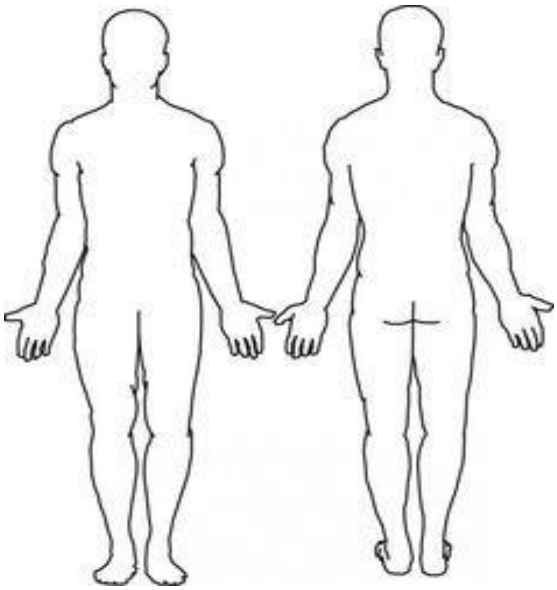
_____

_____

3._____

_____

_____



Are these injuries related to a RECENT car/work accident? ☐ Yes ☐No If yes, please see receptionist.

List other doctors consulted for present complaints and injuries:

Name:_____When consulted & length:_____

Diagnosis:_____Treatment:_____

Present Family Doctor_____Date of last exam_____

Past Health History

What surgeries have you had? _____

_____

List former serious accidents and falls: (auto, work, home, leisure, sports, other) What/When/Symptoms/Treatment/Results

_____

_____

List broken bones:_____

What/When/Remarks_____

List medications and/or dietary supplements:_____

Frequency/Doctor/Side Effects/Remarks_____

_____

Do you have any diagnosed conditions?_____

Environment

Do any of your daily activities contribute to your present condition?_____

Job/ Commute_____

Home Activities_____

Hobbies/ Sports/ Recreation _____

_____

If you have discontinued sports or strenuous activities, why the change?_____

Do you exert yourself-Frequently/Occasionally/Rarely/ Never? Describe how?_____

_____

Please Complete for All Patients 10 years old and YOUNGER

Chiropractic care during pregnancy_____Problems During Pregnancy_____

Type of birth: Normal____Vaginal____Forceps____Breech____Cesarean___Birth took place: At home_____Hospital_____

Problems during labor/ delivery_____Drugs during delivery_____

Obstetrician/midwife_____Pediatrician/ Family MD_____

Immunization history_____

Purpose of this appointment_____

Has your child been treated on an emergency basis? Yes No Describe_____

Childhood diseases: Chicken Pox Mumps Measles Whooping Cough Rubella (German Meas;es)

Medications (include non-prescriptions)_____

Surgeries_____

Has your child ever been involved in a car accident? Yes No Were they injured? Yes No

Explain_____

Has your child ever suffered from:

Dizziness	Muscle Jerking	Bed Wetting	Convulsions	Bronchitis	Tuberculosis	Backaches
Heart Trouble	Broken Bones	Neck Problems	Digestion issues	Hypertension	Anxiety	Arthritis
Runs unevenly	Colds/flu	Poor Appetite	Anemia	Diarrhea	Constipation	Paralysis
Hyperactivity	Hypoglycemia	Sleeplessness	Violent Activity	Fainting	Diabetes	Asthma
Allergies	Growing Pains	Headaches	Neuritis	Ruptures/hernia	Chronic earaches	Orthopedic Problems

Other_____

Circle Current Conditions - Check Former Conditions

PRMARY SYMPTOMS

MUSCULO-SKELETAL

Recurring Headaches

Eye or sinus pain

Facial spasms

Facial/jaw pain

Restricted movement-head/neck

Neck pain

Neck spasms

Poor posture

Upper back pain

Sore, aching “shawl” muscles

Pain-shoulder/arm/hand

Arthritis

Bursitis

Pain beneath/under shoulder blade

Pain around collar bone

Mid back pain

Chest pain

Rib cage pain

Pain beneath/below breast bone

Hiatal hernia

Restricted movement-torso

Scoliosis

Low back pain

Rheumatism

Neuritis

Neuralgia

Lumbago

Painful tailbone

Buttock pain

Hip pain

Sciatica

Swollen/painful/stiff joints- leg/foot

Restricted movement-leg/foot

Leg cramps

Leg pain-lower/upper

Foot/toe pain

Sore/weak muscles

NERVOUS SYSTEM

Hot/cold spots Nervousness Insomnia

Numbness/tingling Personality Change
Depression Dizziness Anxiety
Confusion Fainting Irritability
Forgetfulness Paralysis Tremors
Hiccups Convulsions Tension

EYE, EAR, NOSE & THROAT

Visual disturbances Hearing loss

Dental problems Light sensitivity

Ear discharge Difficulty speaking

Zig zag flashes Nose pain Sinus trouble

Eye strain Nose bleeding Sore throat

Hay fever/allergies Eye inflammation
Nose discharge Visual problems

Difficulty breathing through nose Hoarseness

Chronic earache Sore mouth/gums
Head colds Ear noises Canker sores

RESPIRATORY

Difficulty breathing Asthma Chest colds

Chronic cough Allergies Tuberculosis

Coughing phlegm/blood

CARDIOVASCUL AR

Heart attack Slow beating heart
Poor circulation High blood pressure
Pain over heart Stroke

Low blood pressure Hardening of arteries

Varicose veins Rapid beating heart
Swelling of ankles

SKIN

Skin disorder Itching Boils

Acne Bruise easily Hives

Allergies Shingles Dryness

GENERAL

Fever Sweats Cancer Diabetes

Thyroid disorder Rheumatic fever
Loss of weight Chills
Chronic fatigue Weight trouble

GASTRO-INTESTINAL

Chronic nausea Belching gas

Diverticulitis Vomiting Food allergy

Gastritis/heartburn Hemorrhoids

Vomiting blood Pain over stomach
Liver trouble Ulcers/stomach

Gall bladder trouble Jaundice

Poor appetite Distention of abdomen
Excessive hunger Constipation
Black stool Diarrhea Colitis

Difficulty chewing/swallowing

Bloody stool Excessive thirst
Colitis

GENITO-URINARY

Urine disorder-frequent

Bladder trouble Bed wetting

excessive/scanty/painful/

Kidney infection/stones Prostatis

discolored blood/pus Impotency

FEMALE

Periods-painful/excessive

Hot flashes Menopause symptom

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, /no. U.o On/y IOV 3127/2003

PattentName _____ **Date**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one *statement that applies to you. If two or more statements In one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity

⓪ I have no pain at the moment
① The pain is very mild at the moment.
②. The pain comes andgoes and is moderate.
③The pain is fairly severe at lha moment.
④The pain Is very severe at the moment.
⑤The pain is the worst imaginable at the momenl

Sleeping

⓪I have no trouble sleeping.
①My sleep is slightly disturbed (less than 1 hour sleepless).
②My sleep is mildly disturbed (1-2 hours sleepless).
③My sleep is moderate·ly disturbed (2-3 hours sleepless).
④My sleep is greatly disturbed (3-5 hours sleepless).
⑤**My** sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪I can read as much as I want with no neck pain.
①I can read as much asI want with srighl neck pain.
②I can read as much as I want with moderate neck pain.
③I cannot read as much as I want because of moderate neck pain.
④I can hardly read at all because of severe neck pain.
⑤I cannot read at all because of neck pain.

Concentration

⓪I can concentrate fully when I want with no difficulty.
①I can concentrate fully when I want with slight difficulty.
②I have a fair degree of difficulty concentrating when I want.
③I have a lot of difficulty concentrating when I want.
④I have a great deal of difficulty concentrating when I want
⑤I cannot concentrate at all.

Work

⓪I can do as much work as I want.
①I can only do my usual work but no more.
②I can only do most or my usual work but no more.
③I cannot do my usual wolk
④I can hardly do any work at all.
⑤I cannot do any work at all.

Personal Care

⓪I can look after myself normally without causingextra pain.
①I can look after myself normally but it causes extra pain.
②It is painful to look after myself and I am slow and careful.
③I need some help but I manage most of my personal care.
④I need help every *day* in most aspects or self care.
⑤I do not get dressed, I wash with difficulty and Y inbed.

Lifting

⓪I can rift heavy weights without extra pain.
① I can lift heevy weights but ii causes extra pain.
②Pain prevents me from llftlng heavy weights off the ftoor, but I can manage if they are conveniently positioned(e.g., on a table).
③Pain prevents me from lifting heavy weights off the floor, but I can manage lightto mediumweights if they are convenienUy positioned.
④t can only lilt very light weights.
⑤I cannot lift or carry anything at all.

Driving

⓪I can drive my car without any neck pain.
①I can drive my car as long as I want with slight neck pain.
②I can drive my car as long as I want with moderate neck pain.
③I cannot drive my car as long as I want because of moderate neck pain.
④I can hardly drive at all because of severe neck pain.
⑤I cannot drive my car at all because of neck pain.

Recreation

⓪I am able to engage in all my recreation activities without neck pain.
①I am able to engage in all my usual reaeation activities with some neck pain.
②I am able to engage in most but not all my usual recreation activities because of neck pain.
③I am only able to engage in a few or my usual recreation activities because or neck pain.
④I can hardly do any recreation activities because of neck pain.
⑤I cannot do any recreation activities at all.

Headaches

⓪I have no headaches at all.
①I have slight headaches which come infrequently.
②I have moderate headaches which come infrequently.
③I have moderate headaches which come frequently.
④I have severe headaches which come frequently.
⑤I have headaches almost all the time.

Neck Index ☐

Score= [Sum of all statements selected /(#of sections with ~~a statement selected~~ _ _?)] - - j *Score*

Back Index

Form 81100

rev 312712003

Patient* Name**_____ ***Date_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section.apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain Is very severe and does not vary much.

Sleeping

⓪ I get no pain in **bed.**
① I get pain in **bed but** it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from silting more than 1hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid siltingbecause it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1hour without increasing pain..
③ I cannot stand for longer than 112 hour without Increasing pain.
④ I cannot stand for longer than 10 minutes without Increasing pain.
⑤ I avoid standing because it increases pain Immediately.

Walking

⓪ I have nopain while walking.
① I have some painwhile walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasingpain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases lhe pain but I manage not to change my way of doing ii.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but tt causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only liH very light weights.

Traveling

⓪ I get no pain while traveling.
① I gel some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but ii does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting *my* more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)) x 100] Score