Trostel Chiropractic Ltd.
2487 N. Monroe St.
Decatur, IL 62526
217-872-5452

History Form

Patient Information
Name_____ Date_____
Date of Birth_____ Social Security # _____
Address_____ City_____
State_____ Zip_____ Home Phone_____
Work Phone_____ Cell Phone_____
Primary Care Physician_____ Phone_____
Gender: Male or Female
Marital Status: Married Single Divorced Legally Separated Widowed
Spouses Name _____

Emergency Contact Information
Name _____ Phone #_____
Address_____ City_____
State_____ Zip_____

Insurance Information
Carrier Name_____
Card Holder Name _____
Card Holder Date of Birth _____
Card Holder Social Security # _____

Main Problem
What pain caused you to come to the office?_____
_____
What Caused this pain? _____
_____
When did this pain start?_____
How long does this pain last?_____

How bad is this pain? (please circle the ONE that best applies):
Mild Moderate Severe Intolerable

Circle the word or words that best describe the pain:
Cramping Aching Dull Sharp Shooting Bright Diffuse Lighteninglike Throbbing Nagging Burning Deep Stinging Pressurelike

How often does the pain occur? (Please circle one that applies):
Occasional Frequent Constant

Does this pain travel to any other area? Yes or No
Where?_____
What Makes this pain better?_____
_____
What makes this pain worse?_____
_____
What else have you done to treat this pain?_____
_____

Other Problem
What other pain do you have?_____
What Caused this pain? _____
_____
When did this pain start?_____
How long does this pain last?_____

How bad is this pain? (please circle the ONE that best applies):
Mild Moderate Severe Intolerable

Circle the word or words that best describe the pain:
Cramping Aching Dull Sharp Shooting Bright Diffuse Lighteninglike Throbbing Nagging Burning Deep Stinging Pressurelike

How often does the pain occur? (Please circle one that applies):
Occasional Frequent Constant

Does this pain travel to any other area? Yes or No
Where?_____
What Makes this pain better?_____
What makes this pain worse?_____
_____
What else have you done to treat this pain?_____
_____

Family History

Date_____

Please tell us about the health of your parents, siblings and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

Living/Deceased Heart Disease, Stroke, Cancer, Diabetes,Rheumatoid Arthritis,Multiple Sclerosis,Lung Disease

Father L D
Cause:
Mother L D
Cause:
Sibling M
Child F L D
Cause:
Sibling M
Child F L D
Cause:
Sibling M
Child F L D
Cause:
Sibling M
Child F L D
Cause:
Sibling M
Child F L D
Cause:
Sibling M
Child F L D
Cause:
Sibling M
Child F L D
Cause:

Past and Social History
Are you Employed? Yes or No
Name of Employer _____
Do you drink alcohol? Yes or No How much?_____
Do you use tobacco? Yes or No How much?_____
Do you use recreational drugs? Yes or No

Have you had any illness in the past? _____
_____
_____
Have you had any injuries?_____
_____
_____
Have you been hospitalized?(If yes, what for?)_____
_____
_____
Have you had any surgeries?_____
_____
_____
List any medications that you are taking _____
_____
_____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

_____
Print Name

_____
Patient Signature

_____
Date