

PATIENT HISTORY

Trillium Technology, Inc.

SOC. SEC. NUMBER

0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9

Patient Name: _____

Doctor Name: _____

Comments/Observations: _____

Doctor: (A) (B) (C) (D) (E) (F)

Visit Classification (New Patient):

(1) (2) (3) (4) (5)

DATE

MO.	DAY	YR.
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

1. Current Symptoms

Instructions: Please Mark all of Your Current Symptoms by Filling in the Appropriate Bubbles. If There is Not Enough Space Provided for Your Written Answer, Please Use the Back Side of these Sheets.

HEADACHE PAIN LOCATION

- Left Back of Head Entire Head Right Back of Head
 Left Side Front of Head Right Side
 Left Temple Area Behind the Eyes Right Temple Area Previously Had Headaches

LEFT SIDE

RIGHT SIDE

STIFFNESS	PAIN		PAIN	STIFFNESS	MARK IF YOU HAVE HAD BEFORE NOW
Upper Neck	<input type="checkbox"/>		<input type="checkbox"/>	Upper Neck	<input type="checkbox"/>
Lower Neck	<input type="checkbox"/>		<input type="checkbox"/>	Lower Neck	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>		<input type="checkbox"/>	Shoulder	<input type="checkbox"/>
Upper Back	<input type="checkbox"/>		<input type="checkbox"/>	Upper Back	<input type="checkbox"/>
Upper Arm	<input type="checkbox"/>		<input type="checkbox"/>	Upper Arm	<input type="checkbox"/>
Elbow	<input type="checkbox"/>		<input type="checkbox"/>	Elbow	<input type="checkbox"/>
Middle Back	<input type="checkbox"/>		<input type="checkbox"/>	Middle Back	<input type="checkbox"/>
Forearm	<input type="checkbox"/>		<input type="checkbox"/>	Forearm	<input type="checkbox"/>
Wrist	<input type="checkbox"/>		<input type="checkbox"/>	Wrist	<input type="checkbox"/>
Low Back	<input type="checkbox"/>		<input type="checkbox"/>	Low Back	<input type="checkbox"/>
Hand	<input type="checkbox"/>		<input type="checkbox"/>	Hand	<input type="checkbox"/>
Fingers	<input type="checkbox"/>		<input type="checkbox"/>	Fingers	<input type="checkbox"/>
Hip	<input type="checkbox"/>		<input type="checkbox"/>	Hip	<input type="checkbox"/>
Thigh (front)	<input type="checkbox"/>		<input type="checkbox"/>	Thigh (front)	<input type="checkbox"/>
Thigh (back)	<input type="checkbox"/>		<input type="checkbox"/>	Thigh (back)	<input type="checkbox"/>
Knee	<input type="checkbox"/>		<input type="checkbox"/>	Knee	<input type="checkbox"/>
Shin	<input type="checkbox"/>		<input type="checkbox"/>	Shin	<input type="checkbox"/>
Calf	<input type="checkbox"/>		<input type="checkbox"/>	Calf	<input type="checkbox"/>
Ankle	<input type="checkbox"/>		<input type="checkbox"/>	Ankle	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	Foot	<input type="checkbox"/>	
Toes	<input type="checkbox"/>	<input type="checkbox"/>	Toes	<input type="checkbox"/>	

Nausea Vomiting

Other Symptoms (Please Specify):

DATE THE CURRENT SYMPTOMS STARTED

Approximate Date Exact Date

Month	Day	Year
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Please Indicate What Happened on this Date:

- Date of Motor Vehicle Accident
 Date of Work Injury
 Date of Injury / Trauma
 Date of Re-Injury / Condition got Worse
 Approximate Date Symptoms Started (If No Injury Occurred)

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1. Current Symptoms (cont)

Instructions: ONLY Complete This Section, If You Have Had Your Current Symptoms Before.

WHEN DID YOU HAVE YOUR CURRENT SYMPTOMS BEFORE NOW?

DATE SYMPTOMS STARTED

DATE SYMPTOMS WERE GONE

Month	Day	Year
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Month	Day	Year
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Did You Receive Treatment for These Symptoms? Yes No

If Yes, What Kind of Practioner(s) Did You See?

- Chiropractor
- Medical Doctor
- Physical Therapist
- Specialist
- Emergency Room
- Rehabilitative Therapy
- Chronic Pain Specialist
- Other (Please Specify)

When You Finished That Previous Treatment, How Would You Describe Your Symptoms?

- Completely Gone
- Not Changed by Treatment
- Not as Severe
- Did Not Occur as Often
- Other (Please Specify)

If You Received Treatment from Anyone, Please Provide their Name and Address:

Other Comments:

2. Past History

Instructions: If You Have Had Any of The Following Before, Please Fill in All that Apply.

	Have NOT been Treated For	Required Treatment	No Longer Occurs	Occurs On and Off
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Shoulder Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Shoulder Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Arm/Hand Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Arm/Hand Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Hip Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Hip Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Leg/Foot Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Leg/Foot Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ (Jaw) Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicable Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Conditions (Please Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name and Address of Anyone Providing Treatment:

Other Comments:

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST?

AUTO ACCIDENT(S)

Yes No

Month	Day	Year
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

WORK ACCIDENT(S)

Yes No

Month	Day	Year
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

OTHER TYPE OF TRAUMA

Yes No

Month	Day	Year
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Please Provide Details if an Accident Occurred:

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Patient Name: Trillium Technology, Inc.

3. Current Activities

Instructions: Please Mark All That Apply.

Are You Currently Taking Any of the Following?

- Aspirin
- Tylenol (or product like Tylenol)
- Ibuprofen (like Advil or Motrin)
- Prescription Pain Medication (please name below)
- Other Prescription Drugs (please name below)
- Over the Counter Medications (please name below)
- Vitamins
- Other Substances (Please Specify) _____

Are You Currently Doing Any of the Following?

- Exercise
- Applying Ice
- Applying Heat
- Avoiding Some Tasks at Home
- Avoiding Some Work Activities
- Resting
- Stretching
- Other (Please Specify) _____

Do You Use or Consume Any of the Following?

If YES, at What Rate?

	No						
Tobacco	<input type="checkbox"/>	1/2 Pack a Day <input type="checkbox"/>	1 Pack a Day <input type="checkbox"/>	1.5 Packs a Day <input type="checkbox"/>	2 Packs a Day <input type="checkbox"/>	2+ Packs a Day <input type="checkbox"/>	Other Quantity <input type="checkbox"/>
Alcohol	<input type="checkbox"/>	2 Drinks/Beers a Week <input type="checkbox"/>	3-6 Drinks/Beers a Week <input type="checkbox"/>	1-2 Drinks/Beers a Day <input type="checkbox"/>	2+ Drinks/Beers a Day <input type="checkbox"/>	Other Quantity <input type="checkbox"/>	
Recreational Drugs (street drugs)	<input type="checkbox"/>	<input type="checkbox"/> Yes. Please Describe or Discuss with Doctor _____					
Caffeinated Beverages	<input type="checkbox"/>	1-4 Cups/Cans a Week <input type="checkbox"/>	1 Cup/Can a Day <input type="checkbox"/>	2-3 Cups/Cans a Day <input type="checkbox"/>	3+ Cups/Cans a Day <input type="checkbox"/>	Other Quantity <input type="checkbox"/>	

4. Family History

Instructions: Please Mark All That That Apply.

Have You or Any Member of Your Family Ever Been Told They Have:

	No	Yes
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Conditions You Have Been Told Run in Your Family (Please List)		<input type="checkbox"/>

FOR OFFICE USE ONLY

Comments

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5. Motor Vehicle Accident

Instructions: ONLY Complete This Section If Your Injuries Were a Result of a Motor Vehicle Accident.

At the Time of the Accident, You Were:

- Driving
- A Passenger in the Front Seat
- A Passenger in the Back Seat

At the Time of the Accident, Your Vehicle Was:

- Stopped
- Slowing
- Accelerating
- Moving Sideways
- Moving in Reverse

YOUR Vehicle is Best Described As a:

- Subcompact Car
- Compact Car
- Full-size Car
- Small Truck
- Full-size Truck
- Motorcycle
- Other (Please include Make and Description)

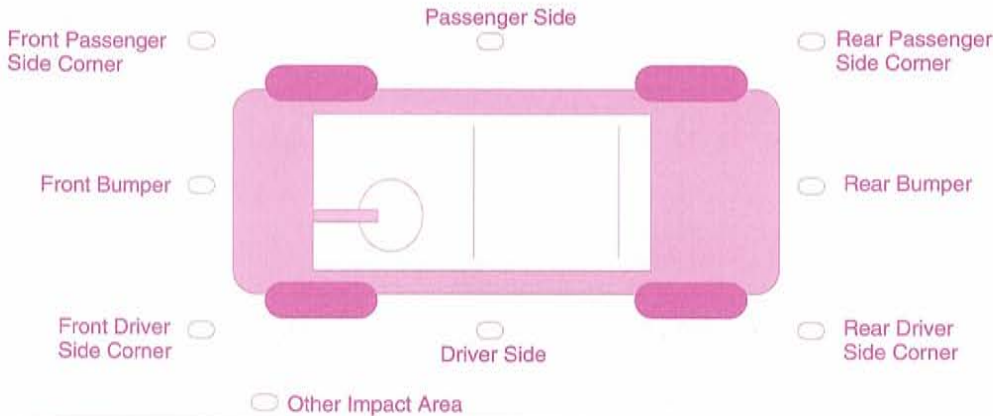
The OTHER Vehicle Involved in the First Impact is Best Described As a:

- Subcompact Car
- Compact Car
- Full-size Car
- Small Truck
- Full-size Truck
- Motorcycle
- Other (Please include Make and Description)

During the First Impact:

- Another Vehicle Struck Your Vehicle
- Your Vehicle Struck Something First (Please Indicate What)
 - Another Vehicle
 - A Tree
 - A Guard Rail
 - An Embankment
- Other (Please Specify)

PLEASE INDICATE YOUR VEHICLE'S FIRST IMPACT AREA



The Vehicle I Was In Had a Second Impact (Please Describe Below)

At the Time of the Accident, YOUR Vehicle was Moving:

- Slowly
- At a Moderate Speed
- Quickly
- Not At All

At the Time of the Accident, The OTHER Vehicle was Moving:

- Slowly
- At a Moderate Speed
- Quickly
- Not At All

CHOOSE ALL THAT APPLY AT THE TIME OF THE ACCIDENT

	Yes	No
You Were Wearing Your Seat Belt	<input type="checkbox"/>	<input type="checkbox"/>
You Were Wearing Your Shoulder Belt	<input type="checkbox"/>	<input type="checkbox"/>
Your Vehicle's Air Bag Deployed	<input type="checkbox"/>	<input type="checkbox"/>
You Hit the Steering Wheel With Your Head	<input type="checkbox"/>	<input type="checkbox"/>
You Hit the Steering Wheel With Your Chest	<input type="checkbox"/>	<input type="checkbox"/>
You Lost Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
You Were Expecting the Impact and Braced Yourself	<input type="checkbox"/>	<input type="checkbox"/>
You Were Caught Completely By Surprise	<input type="checkbox"/>	<input type="checkbox"/>

Other Details

You Were Looking To the Right Straight Ahead To the Left

You Hit the Inside of the Vehicle With Some Other Body Part(s) (Please Specify)

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Patient Name:

Trillium Technology, Inc.

6. Work Injury

Instructions: ONLY Complete This Section If Your Injuries Were a Result of a Work Related Accident.

My Injury Occurred:

- While I was Carrying an Object and Lost My Balance
- While I was Struck By a Falling Object (Please Describe) _____
- While I was Driving on the Job
- Over Time, While I was Doing the Same Task Over and Over (Please Describe) _____
- While I was Lifting Something (Please Answer Additional Lifting Questions Below)
- Other (Please Describe) _____

I did did not Report this Incident In Writing at Work

I have have not Seen Another Health Care Provider for Treatment Related to this Injury

Other Comments _____

IF YOU WERE INJURED WHILE LIFTING, PLEASE COMPLETE ALL ITEMS THAT APPLY TO YOU:

I Suffered the Injury While Lifting:

- From the Floor
- From a Surface About Waist Height
- From a Surface Over My Head
- Other (Please Describe) _____

When I was Lifting, I:

- Had My Back Straight
- Was Bent at the Waist
- Twisted to the Side
- Other Action (Please Describe) _____

The Object I Lifted Was:

- 2 - 5 Pounds
- 5 - 10 Pounds
- 10 - 15 Pounds
- 15 - 20 Pounds
- 20 - 25 Pounds
- Greater Than 25 Pounds
- Other Comments _____

How Would You Describe the Pain Immediately Following Your Injury:

- Grabbing Feeling
- Sharp Pain in One Spot
- Sharp Pain with Radiation of Symptoms
- Popping Feeling
- Dull Ache
- Other (Please Describe) _____

IF YOU FELL AT WORK, PLEASE COMPLETE ALL ITEMS THAT APPLY TO YOU:

I Fell at Work:

- Onto the Surface I was Walking On
- From a Surface 2 - 4 Feet High
- From a Surface 4 - 6 Feet High
- From a Surface 6 - 8 Feet High
- From a Surface Higher Than 8 Feet
- Other (Please Describe) _____

When I Fell, I Landed On: (choose all that apply)

- My Rear End
- My Back
- My Right Side
- My Left Side
- My Stomach
- My Knees
- My Outstretched Arms
- Comments _____

I Hit My: (choose all that apply)

- Head
- Right Elbow
- Left Elbow
- Right Hand / Wrist
- Left Hand / Wrist
- Back
- Tail Bone
- Right Knee
- Left Knee
- Other Body Part (Please Describe) _____

7. Other Injury

Instructions: ONLY Complete This Section If Your Injuries Were a Result of Some Other Incident (not Motor Vehicle or Work Related).

My Injury Occurred:

- While I was Lifting (Please Specify) _____
- When I Slipped and Fell
- When I Coughed or Sneezed
- When I Straightened Up from Bending
- When I Twisted at the Waist
- When I Looked Over My Shoulder

If Your Injury Occurred In Some Way Not Described, Please Describe it Here: _____

If You Fell, Please Choose All That Apply:

- The Surface was Wet
- The Surface Was Icy
- The Rug / Carpet was Uneven
- The Surface had Some Liquid on It
- I Tripped Over an Object on the Floor
- Other (Please Describe) _____

The Injury Occurred at:

- Your Home
- Outside Your Home (Please Describe) _____

