Dr. Randall D. Trester
West 1st Chiropractic Wellness Centre

3 - 1864 West 1st Ave
Vancouver BC
V6J 1G5

Tel 604 736 8353
Fax 604 736 8350

www.drrandalltrester.com

a division of
Dr. Randall D. Trester Chiropractic Corporation

Confidential Patient Intake Form

FULL NAME | EMPLOYER

ADDRESS | EMPLOYER'S ADDRESS

CITY | PROVINCE | POSTAL CODE | CITY | PROVINCE | POSTAL CODE

HOME PHONE | EMAIL | WORK PHONE | OCCUPATION

BIRTH DATE (D/M/Y) | MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SPOUSE'S NAME | SPOUSE'S EMPLOYER

CARE CARD NUMBER

IN EVENT OF EMERGENCY, WHO SHOULD WE CONTACT? | RELATIONS | HOME PHONE NO.

ADDRESS | WORK PHONE NO.

What health concern has brought you to our office?

Please describe the pain & its location:

When did condition begin? Is this condition getting worse? ☐ Yes ☐ No ☐ Comes and goes ☐ Constant

Is this condition interfering with your (please circle): Work Sleep or Daily routine

If so, please explain:

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain:

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic care ☐ None ☐ Other

How did you hear about our clinic?/How were you referred?

Feel free to share your chiropractic experience with family & friends. Dr. Trester is always accepting new patients, would like to help others and intends on building a community of well-adjusted spines.

Name of Medical Doctor:

Are you currently taking any medication?

☐ Yes Please list:

☐ No

Have you seen a Chiropractor in the past?

☐ Yes Date of last visit & explain:

☐ No Chiropractor's name:

On a scale of 1-10, what is your commitment to getting rid of this problem?

Are you interested in preventing your current problem from occurring again; and would you like to receive information on how to do so?
☐ Yes ☐ No

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Stress Survey

Please rate the following on a 10 point scale: 10 high, 0 low

Physical STRESS level (posture, sitting, standing, lifting, twisting) /10

Chemical STRESS level (coffee, alcohol, cigarettes, drugs, diet) /10

Emotional STRESS level (deadlines, relationship, responsibilities) /10

Habits of Daily Living

Please circle that which applies best to you;

Physical Activity Level Not so good Good Great

How many times a week do you exercise?

What form of exercise?

Nutritional Intake Not so good Good Great

Vitamins/Herbs/Minerals:

Posture Not so good Good Great

Are you wearing ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

What is the age of your mattress? Is it comfortable? ☐ Yes ☐ No

Smoking Habits None Some Frequently

If you smoke, how long have you been doing so? Number/day?

Intake of Caffeine/Alcohol None Some Frequently

History of car accidents/falls/injuries None Some Frequently

Please describe previous occurrences:

Health History

Circle "Yes" or "No" to indicate if you have any of the following:

Alcoholism	Yes	No	Fever (prolonged)	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
AIDS/HIV	Yes	No	Frequent Colds	Yes	No	Numbness	Yes	No	Tiredness	Yes	No
Allergy Shots	Yes	No	Glaucoma	Yes	No	Osteoarthritis	Yes	No	TMJ (Jaw)	Yes	No
Anemia	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tremors	Yes	No
Arthritis	Yes	No	Hearing Loss	Yes	No	Pinched Nerve	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Heart Attack	Yes	No	Pneumonia	Yes	No	Tumors, Growths	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Prostate Problem	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Herniated Disc	Yes	No	Psychiatric Care	Yes	No	Whooping Cough	Yes	No
Chemical Dependency	Yes	No	High Blood Pressure	Yes	No	Rheumatic Fever	Yes	No	Vision Problems	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Rheumatoid Arthritis	Yes	No			
Difficulty Breathing	Yes	No	Infertility	Yes	No	Ringing in Ears	Yes	No	**Women Only**		
Dizziness	Yes	No	Kidney Disease	Yes	No	Sinus Infections	Yes	No	Hysterectomy	Yes	No
Emphysema	Yes	No	Liver Disease	Yes	No	STD's	Yes	No	Miscarriage	Yes	No
Epilepsy	Yes	No	Lowback Pain	Yes	No	Stroke	Yes	No	Menopause	Yes	No
Headaches	Yes	No	Midback Pain	Yes	No				Premenstrual Syndrome	Yes	No
			Migraines	Yes	No				Irregular Menses	Yes	No
									Cramps	Yes	No
									Breast Problems	Yes	No

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Health History cont'd

Please list any other serious medical condition(s) you have had:

Please list anything that you may be allergic to:

Date of last physical exam?

Any surgeries?

For Women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? Nursing? ☐ Yes ☐ No

Date of last menstrual period:

Exceeding your expectations

What are your expectations from your chiropractic care?

What are your long-term health goals?

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance.

X

SIGNATURE DATE

Dr. Randall D. Trester
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THIS SIDE FOR OFFICE USE ONLY

CASE STUDY

X-RAY TAKEN:

DIAGNOSIS:

FREQUENCY OF TREATMENT:

DR. ASSIGNED:

ADJUSTMENT: TODAY NEXT VISIT

ICD-9-CM / DIAGNOSIS CODING

1

839.00	Cervical Subluxation Complex
739.1	Cervical Segmental Dysfunction
847.0	Cervical Sprain/Strain Complex
723.3	Cervical Brachial Radicultis
728.8	Cervical Myofascitis
723.2	Cervical Cranial Syndrome
721.0	Cervical Spondylosis
722.4	Cervical Disc Degeneration
784.0	Cephalia
307.81	Tension Headache
728.5	Cervical Hypermobility Syndrome
723.0	Cervical Canal Stenosis
346.1	Migraine (common)
524.6	TMJ Syndrome
333.83	Torticollis

2

839.21	Thoracic Subluxation Complex
739.2	Thoracic Segmental Dysfunction
847.1	Thoracic Sprain/Strain Complex
722.51	Thoracic Disc Degeneration
721.2	Thoracic Spondylosis
333.0	Thoracic Outlet Syndrome
739.4	Costovertebral/Stemal Somatic Dysfunction
848.2	Chondrostemal Joint Sprain/Strain
737.30	Scoliosis (idiopathic)
754.2	Scoliosis (congenital)
737.1	Kyphosis (acquired)
737.10	Kyphosis (acquired postural)
737.0	Kyphosis (adolescent-postural)

3

839.20	Lumbar Subluxation Complex
739.3	Lumbar Segmental Dysfunction
847.2	Lumbar Sprain/Strain Complex
722.10	Lumbar Disc Syndrome
724.3	Sciatic Neuralgia
756.19	Supermumerary (transitional) Vert
722.52	Lumbar Disc Degeneration
721.3	Lumbar Spondylosis
724.02	Lumbar Canal Stenosis (IVF Encroachment)
724.8	Lumbar Facet Syndrome
756.12	Spondylolidthesis

4

839.42	Sacroiliac Subluxation Complex
846.1	Sacoiliac Sprain/Strain

MISCELLANEOUS

728.85	Muscle Spasms
780.4	Dizziness
782.0	Paresthesia/Hypesthesia
733.0	Osteoporosis