

# Welcome to Frostwood Chiropractic

## Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F    Age \_\_\_\_\_    Birthdate \_\_\_\_\_

Married     Widowed     Single     Minor

Separated     Divorced     Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse/Parent Employer \_\_\_\_\_

**Referral Source**

Friend/Family     Insurance     Website     Internet

Yellow Pages     Other \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Insurance

Policy Holder's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_    SSN \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Do you have Medicare?  Yes  No

Is patient covered by additional insurance?  Yes  No

**AUTHORIZATION, ASSIGNMENT & RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Frostwood Chiropractic P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Frostwood Chiropractic P.A. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## Phone Numbers

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

**IN CASE OF EMERGENCY** (individual you do NOT live with)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Accident Information

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident:  Auto     Work     Home     Other

To whom have you made a report of your accident?

Auto Insurance     Employer     Worker Comp.     Other

Attorney/Adjuster Name (if applicable) \_\_\_\_\_

Attorney/Adjuster Phone (\_\_\_\_\_) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) \_\_\_\_\_

Type of Pain:     Sharp     Dull     Throbbing     Numbness     Aching     Shooting

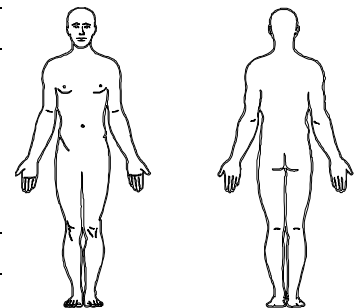
Burning     Tingling     Cramps     Stiffness     Swelling     Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your     Work     Sleep     Daily Routine     Recreation

Activities or movements that are painful to perform     Sitting     Standing     Walking     Bending     Lying Down     Other



# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  Chiropractic  None  
 Other \_\_\_\_\_

Name and Phone # of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last:      Physical Exam \_\_\_\_\_      Spinal Exam \_\_\_\_\_      Blood Test \_\_\_\_\_  
                          Spinal X-Ray \_\_\_\_\_      Chest X-Ray \_\_\_\_\_      Urine Test \_\_\_\_\_  
                          Dental X-Ray \_\_\_\_\_      MRI, CT-Scan \_\_\_\_\_      Other \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Have you ever been in an auto accident?  Past Year  Past 5 Years  Over 5 Years  Never

If so, describe \_\_\_\_\_

Age of mattress \_\_\_\_\_  Comfortable  Uncomfortable

Do you wear  Heal lifts  Sole lifts  Inner soles  Arch Supports

<b>EXERCISE</b>	<b>WORK ACTIVITY</b>	<b>HABITS</b>
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking      Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol      Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks      Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level      Reason _____

<b>Injuries/Surgeries</b>	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Please check if you have **ever** had any of the following:

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV      | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Suicide Attempt   |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Parkinson's      | <input type="checkbox"/> Thyroid Problem   |
| <input type="checkbox"/> Anorexia      | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza          | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Tonsillitis       |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Pinched Nerve    | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Tumor             |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Malaria            | <input type="checkbox"/> Polio            | <input type="checkbox"/> Typhoid Fever     |
| <input type="checkbox"/> Breast Lump   | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Gonorrhea      | <input type="checkbox"/> Migraine           | <input type="checkbox"/> Prosthesis       | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Bulimia       | <input type="checkbox"/> Gout           | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Whooping Cough    |
| <input type="checkbox"/> Chorea        | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid       | <input type="checkbox"/> Other _____       |

<b>Medications</b>	<b>Allergies</b>	<b>Vitamins/Herbs/Supplements</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Review of Systems

Please check if you currently experience or have experienced any of the following symptoms within the past 6 months.

<p style="text-align: center;"><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Convulsions <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tremors	<p style="text-align: center;"><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Belching or Gas <input type="checkbox"/> Colitis <input type="checkbox"/> Colon Problems <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult Digestion <input type="checkbox"/> Distension of Abdomen <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Gall Bladder problems <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Intestinal Worms <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver problems <input type="checkbox"/> Nausea <input type="checkbox"/> Pain over Stomach <input type="checkbox"/> Poor appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood	<p style="text-align: center;"><b>EYES, EARS, NOSE &amp; THROAT</b></p> <input type="checkbox"/> Colds <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Deafness <input type="checkbox"/> Dental Decay <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ear Noises <input type="checkbox"/> Enlarged Glands <input type="checkbox"/> Enlarged Thyroid <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing Vision <input type="checkbox"/> Gum Disease <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Sore Throat <input type="checkbox"/> Tonsillitis	<p style="text-align: center;"><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Hardening of Arteries <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Pain over Heart <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Slow Heart Beat <input type="checkbox"/> Swelling in Ankles
<p style="text-align: center;"><b>MUSCLE &amp; JOINT</b></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Neck Pain/Stiffness <input type="checkbox"/> Pain between Shoulder Blades Pain or Numbness in: <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Knees <input type="checkbox"/> Feet <input type="checkbox"/> Painful tail bone <input type="checkbox"/> Poor Posture <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Swollen Joints	<p style="text-align: center;"><b>RESPIRATORY</b></p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Spitting up Blood <input type="checkbox"/> Spitting up Phlegm <input type="checkbox"/> Wheezing	<p style="text-align: center;"><b>SKIN</b></p> <input type="checkbox"/> Boils <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Dryness <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Varicose Veins	<p style="text-align: center;"><b>GENITOURINARY</b></p> <input type="checkbox"/> Bed wetting <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Painful Urination <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Pus in Urine
<p style="text-align: center;"><b>WOMEN ONLY</b></p> <input type="checkbox"/> Congested Breasts <input type="checkbox"/> Cramps or backache <input type="checkbox"/> Excessive Menstrual Flow <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Menopausal symptoms <input type="checkbox"/> Painful Menstruation <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Slow Heart Beat			

Please describe/explain any treatment you have had or are currently receiving for the symptoms checked above.  
 Please also note any other health problems you have that may not have been covered on this form.

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***Thank You!***