

**FROGLEY CHIROPRACTIC CENTER**

Today's Date

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home Email \_\_\_\_\_ What city were you born in? \_\_\_\_\_

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Which email address would you like us to use to communicate with you? (check one)  Home

Contact Method (check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email

Date of Birth  Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island  
 Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  
 Tagalog  Vietnamese  Italian  Korean  I choose not to specify

Do you currently smoke tobacco of any kind?  Yes  Former smoker  Never been a smoker

If yes, how often do you smoke:  Current every day smoker  Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

0  1  2  3  4  5  6  7  8  9  10  
No interest Very Interested

**Current medications, including frequency and dosage if known. If there are no current medications, check here:**

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

**List any known allergies you have had to any medications.**

**If no allergies are known, check here:**

1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

**Please list your condition(s) for treatment today in our office beginning with the most severe: \_\_\_\_\_**

**Has any doctor diagnosed you with Hypertension presently?  Yes  No If yes, describe: \_\_\_\_\_**

**Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II**

***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?  Yes  No  Not Sure***

***If yes, other comments regarding Diabetes: \_\_\_\_\_***

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?  Yes  No**

Have you been treated for these symptoms: Yes/ No If yes, who: \_\_\_\_\_

Have you ever been treated by a Chiropractor? Yes / No If yes, who: \_\_\_\_\_

**Family History: (Circle all that apply)**

Cancer: Father Mother Brother Sister

Diabetes: Father Mother Brother Sister

Hypertension: Father Mother Brother Sister

**Review of Systems:** (Circle Present, Past or No)

Heart Attack- Present / Past / No

Jaw Pain- Present / Past / No

Joint Stiffness- Present / Past / No

Broken Bones- Present / Past / No

Difficulty Sleeping- Present / Past / No

**Method of Payment**

Please initial the method you prefer to use to pay for services rendered, then sign below.

\_\_\_\_\_ I will be **Self Pay**. I have no applicable health insurance and will pay for my services with cash, check or debit/credit card.

\_\_\_\_\_ I have **Health Insurance**. Please give appropriate cards to our staff so we can verify your chiropractic coverage.

\_\_\_\_\_ I have **Medicare**. Please give your card to our staff. Do you have a secondary insurance? Yes/ No

\_\_\_\_\_ I have **Medicaid**. Please give your card to our staff.

\_\_\_\_\_ I have been injured in an **Automobile Accident**.

\_\_\_\_\_ I have been injured on the job and will be filing **Workman's Compensation**.

I hereby authorize Frogley Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release records to anyone that I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not be given to anyone without my written consent. I authorize payment directly to Frogley Chiropractic Center from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment or make a payment directly to me. By signing your name below, you verify the accuracy of your medical and/or accident history and further certify that you present to Frogley Chiropractic Center for evaluation and treatment of a health related condition and for no other purpose.

\_\_\_\_\_

Signature of patient, or of Guardian authorizing care

\_\_\_\_\_

Date

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ Location \_\_\_\_\_

Did you report to proper authorities? \*Police? Yes/ No \*Employer? Yes/ No

Were you the: \*Driver: Yes/ No \*Front seat passenger: Yes/ No \*Back seat passenger: Yes/ No

What type of vehicle were you in: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

What other vehicle was involved: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

How many passengers, EXCLUDING you, were in the vehicle with you? \_\_\_\_\_

Where was the damage located on your vehicle? Please Circle all that applies. \*Rear \* Front \* Passenger's Side \*Driver's Side

Describe how the crash happened:

\_\_\_\_\_  
\_\_\_\_\_

How were the roads? Dry/ Wet Were you wearing a seat belt? Yes/ No

Did the vehicle have Head Rests? Yes/ No If yes, were they Up/ Down or Unknown

Which way was your head turned? \_\_\_\_\_ Were you Aware/ Unaware of the impending collision?

Did your body strike anything inside of the vehicle? Yes/ No If yes, what did you strike \_\_\_\_\_

Which way was your body thrown? Front to back / Side to side

Did your jaw hit anything? Yes/ No Has it been popping since? Yes/ No

Were you dazed? Yes/ No Or knocked unconscious? Yes/ No

Did you have immediate pain after the crash? Yes/ No If yes, where \_\_\_\_\_

Did you go to the Emergency Room from the scene? Yes/ No If yes, where \_\_\_\_\_

Were you taken by ambulance? Yes/ No Were you taken by the vehicle you were in? Yes/ No

What was done? Please circle all that applies. \*Examined \*X-rays \*CT scans \*Prescribed medication \*Work note

Have you been treated since then? Yes/ No If yes, where/when \_\_\_\_\_

Do you have any prior car accidents? Yes/ No If yes, when \_\_\_\_\_

Do you have any prior slips or falls? Yes/ No If yes, when \_\_\_\_\_

Do you have an attorney representing you in this case? Yes/ No If yes, list their name, phone number and address:

\_\_\_\_\_

By signing your name below, you certify the accuracy of your medical and/or accident history to the best of your knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_