CHART NUMBER: _____

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** _____

Mobile Phone _____

Secondary Phone _____

Home Email _____

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

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Contact Method *(check one)*

❑ Mobile Phone ❑ Secondary Phone ❑ Home Email

Age: ☐ **Date of Birth:** ___/___/_____ **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: ❑

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) _____

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

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

_____

*HAVE YOU BEEN TREATED FOR THESE SYMPTOMS: YES/ NO IF YES, WHO: _____ WHEN: _____

*HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? YES / NO IF YES, WHO: _____ WHEN: _____

*HAVE YOU HAD AN X-RAY, CT SCAN OR MRI OF YOUR SPINE IN THE PAST YEAR? ❑ Yes ❑ No

What daily activity(s) have been restricted due to the pain: _____

Overall, how many minutes/ hours are you able to perform daily activity(s) since onset: _____

Along with Chiropractic Care, are you seeking Nutritional Consult? ❑ Yes ❑ No

FAMILY HISTORY: (CIRCLE ALL THAT APPLY)
Cancer: Father Mother Brother Sister
Diabetes: Father Mother Brother Sister
Hypertension: Father Mother Brother Sister

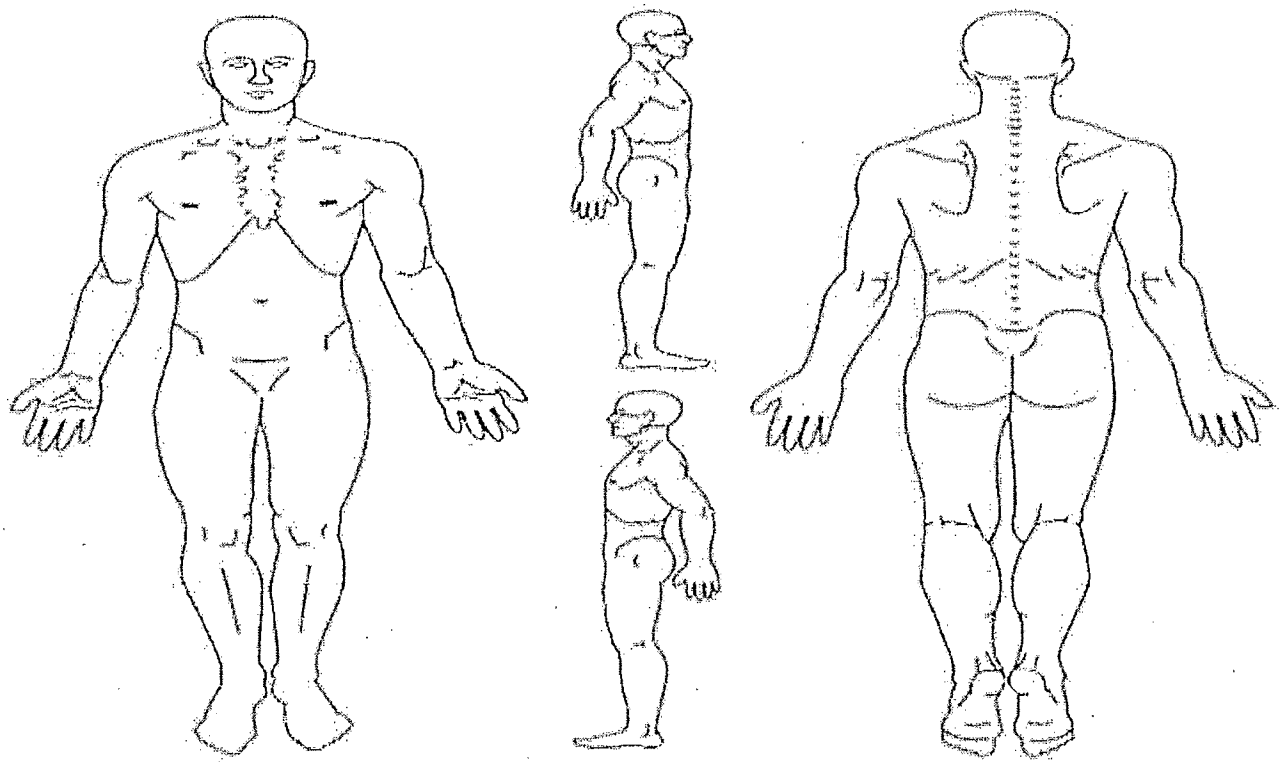
REVIEW OF SYSTEMS: (CIRCLE PRESENT, PAST OR NO)
Heart Attack- Present / Past / No
Jaw Pain- Present / Past / No
Joint Stiffness- Present / Past / No
Broken Bones- Present / Past / No
Difficulty Sleeping- Present / Past / No

Medical Conditions: (Circle all that apply)
Arthritis Cancer Diabetes Heart Disease Hypertension Stroke Asthma Psychiatric Illness
*Other*_____

Please list all Surgeries: _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)	☐ Frequently (51-75% of the day)	☐ Occasionally (26-50% of the day)	☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp	☐ Ache	☐ Numb	☐ Shooting
☐ Burning	☐ Tingling	☐ Throbbing	☐ Other _____

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 **Care Credit** or would like to *apply today*.

_____ 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