APPLICATION FOR CARE AT FRAUM CENTER FOR RESTORATIVE HEALTH

Who may we thank for referring you:

Patient ____________________Internet_______Newspaper_________ Other_______________

PLEASE COMPLETE WITH BLACK INK

PATIENT DEMOGRAPHICS

Name:______________________________________ Birth Date:___ /___ /_____ Age:______ ☐ Male ☐ Female

Address:____City: _________________________State: ____Zip:________

Email:____Home Phone: ____________________Mobile Phone:_____________________

Work Phone: _______________________Social Security Number: __________________Drivers License #:______________________

Martial Status: ☐ Married ☐ Single ☐ Divorced

Do you have insurance? ☐ Yes ☐ No Insurance Carrier(s): ___________________________ Policy # _______________________

Employer: ____Occupation: ____

Spouse's Name: ____ Spouse's Employer:____

Number of children and ages:____

Emergency Contact: ____Relationship:_________________ Phone: __________________

HISTORY OF COMPLAINT

Please indentify the condition(s) that brought you to this office:

First:____Second:____

Third:____Fourth:____

On a scale of **1** to **10,** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number:**

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _______ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant OR ☐ I experience it off and on during the day OR ☐ It comes and goes throughout the week

How did the injury happen? ____

____

Height:________ Weight: _________

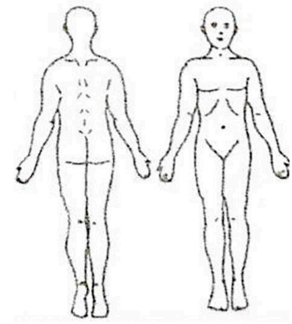
Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, when:_____________ By whom?_________________

How long were you under care:___________________________What were the results?_______________________________________

Name of Previous Chiropractor:____ ☐ N/A

*PLEASE MARK the areas on the diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms?____

What makes them feel worse?____

List Restriced Activity:	Current Activity Level:	Usual Activity Level:
____________________:	____________________	____________________
____________________:	____________________	____________________
____________________:	____________________	____________________
____________________:	____________________	____________________

Is your problem the result of ANY type of accident: ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes If yes how many times?_______________

When was the last episode? _______ How did the injury happen? _______________________________________

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment:_________and who provided it: _______

How long ago? _____ What were the results? ☐ Favorable ☐ Unfavorable –> please explain:

____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with any of the following conditions, please indicate with a ***P*** for in the **Past**, ***C*** for **Currently** have and ***N*** for **Never** have had:

____Broken Bone ____Dislocations ____Tumors ____Rheumatoid Arthritis _____Fracture ____Disability ___Cancer

___Heart Attack ____ Osteo Arthritis ____Diabetes ____Cerebral Vascular ____Other serious conditions

PLEASE identify **All PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

HOW LONG AGO TYPE OF CARE RECIEVED BY WHOM

Injuries:____

Surgries:____

Childhood Diseases:____

Adult Diseases:____

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes ——> How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs—> ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Recreational Activities/Exercise Regime: How does your present problem affect the following:

____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister's ☐ brother's ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. **Any** other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes:_______________________________

I hereby authorize payment to be made directly to Fraum Center for Restorative Health, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Fraum Center For Restorative Health for any and all services I receive at this office.

_______________________________________ ____ /____ /______

Patient or Authorized Persons Signature **Date Completed**

_______________________________________ ____ /____ /______

Doctors Signature **Date Form Reviewed**

Patient's Name: ______________________________ HR#: _______________ Date: ____ /____ /______

ACTIVITIES FOR LIFE

PLEASE IDENTIFY HOW YOUR CURRENT CONDITION IS AFFECTING YOUR ABILITY TO CARRY OUT ACTIVITIES THAT ARE ROUTINELY PART OF YOUR LIFE:

ACTIVITIES:	EFFECT:
Carry Children/Groceries	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Sit to Stand	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Climb Stairs	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Pet Care	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Extended Computer Use	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Lift Children/Groceries	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Read/Concentrate	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Getting Dressed	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Shaving	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Sexual Activities	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Sleep	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Static Sitting	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Static Standing	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Yard work	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Walking	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Washing/Bathing	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Dishes	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Laundry	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Garbage	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Driving	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
Other: ______________________	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: ____

____

____

____

Patient signature: ____ **Today's Date:**____/_____/______

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PLEASE IDENTIFY HOW YOUR CURRENT CONDITION IS AFFECTING YOUR ABILITY TO CARRY OUT ACTIVITIES THAT ARE ROUTINELY PART OF YOUR LIFE:

Please mark ***P*** for in the ***Past***, ***C*** for ***Currently*** have, or ***N*** for ***Never***.

___Headache	___Pregnant(Now)	___Dizziness	___Prostate Problems	___Ulcers
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Impotence/Sexual Dysfunction	___Heartburn
___Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Mid Back Pain	___Pain w/Cough/Sneeze	___Ringing in Ears	___Menopausal Problems	___Asthma
___Low Back Pain	___Foot or Knee Problems	___Hearing Loss	___Menstrual Problem	___Difficulty Breathing
___Hip Pain	___Sinus/Drainage Problem	___Depression	___PMS	___Lung Problems
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Bed Wetting	___Kidney Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Learning Disabilty	___Gall Bladder Trouble
___Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Eating Disorder	___Liver Trouble
___Numb/Tingling legs, feet, toes		___Allergies	___Trouble Sleeping	___Hepatitis (A,B,C)