

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 1 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ In what city were you born? _____

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)

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