Frazetta Family Chiropractic **Date: _____**
New Patient Intake Form **Age: ____**

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ **Work Phone (_____) _____-_____**

Cell Phone (_____) _____-_____ **Email _____**

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data _____

Employer _____

Your Occupation _____

Spouse Data _____

First Name _____ Middle Initial ____ Last Name _____

Cell Phone (_____) _____-_____ **Spouse Date of Birth _____/_____/_____**

Emergency Contact _____

Contact Name _____ **Relationship to Patient _____**

Contact Home Phone (_____) _____-_____ **Cell Phone (_____) _____-_____**

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

□ Mold	□ Seasonal	□ Milk or Lactose	□ Animal
□ Chemical _____	Sulfites	□ Wheat/Glutens	□ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Drink Water:	□ <64 oz/day	□>64 oz/day	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Sleep:	□<8 hours/night	□ >=8 hours/night	Insomnia □

Other _____

Family History: (Circle all that apply)

Arthritis	□ Parent	□ Sibling
Cancer	□ Parent	□ Sibling
Diabetes	□ Parent	□ Sibling
Heart Disease	Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Accidents:

Date of Accident: _____
Type: _____
Treatment for: _____

Date of Accident: _____
Type: _____
Treatment for: _____

Occupational Activities: (Circle one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper

□ Other _____

Women:

How many children do you have? ___ Are you pregnant? _____ Are you nursing? _____

Date of last menstrual cycle: _____ Are you taking birth control? _____

Review of Systems – (Mark if you have had trouble with any of the following)

GENERAL:
__Lethargy/Weakness
__Recurring Fever
__Recent weight loss or gain
__Dizziness
__Fever
__Chills
__ Other: _____

RESPIRATORY:
__Chronic/Frequent Cough
__Spitting Up Blood
__Asthma or Wheezing
__Shortness of Breath
__Exercise Intolerance
__Sleep Apnea
__Emphysema
__Other: _____

MUSCULOSKELETAL:
__Arthritis
__Muscle Pain
__Muscle Cramps
__Muscle Stiffness
__Joint Pain or Swelling
__Neck Pain
__Back Pain

HEENT:
__Headaches
__Visual Changes
__Sinus problems
__Nose Bleeds
__Hearing Loss
__Ear Pain
__Ringing in Ears
__Sore Throat
__Hoarseness
__Swollen Glands
__Other: _____

GASTROINTESTINAL:
__Loss of Appetite
__Nausea/Vomiting
__Diarrhea
__Constipation
__Abdominal Pain
__Stomach Ulcer
__Bloating/Cramping
__Heartburn
__Rectal Bleeding
__Hemorrhoids
__Hepatitis
__Cirrhosis
__Other: _____

BLOOD/LYMPH:
__Anemia
__Bleeding
__Bruising
__Blood Clots
__Past Transfusions
__Leukemia
__Lymphoma
__HIV/AIDS
__Sickle Cell
__Other: _____

URINARY:
__Frequent Urination
__Burning or Painful Urination
__Incontinence
__Hesitancy
__Urgency
__Blood in Urine
__Other: _____

ALLERGIES:
__Seasonal
__Medication
__Food
__Other: _____

FEMALE:
__Painful Sex
__Vaginal Discharge
__Breast Pain or Lumps
__Hot Flashes
__Menstrual Irregularity
__Loss of Libido
__Menopause
__Sexually Transmitted Disease
__Other: _____

SKIN/HAIR:
__Rashes
__Itching
__Lesions
__Hives
__Psoriasis
__Mole Changes
__Change in skin color
__Change in hair
__Nail Problems
__Other: _____

NEUROLOGICAL:
__Frequent Headaches
__Migraines
__Dizziness
__Fainting
__Memory Loss
__Poor Balance
__Numbness or Tingling
__Pins and Needles
__Limb Weakness
__Seizures
__Stroke
__Tremors
__Head Injury
__Trauma

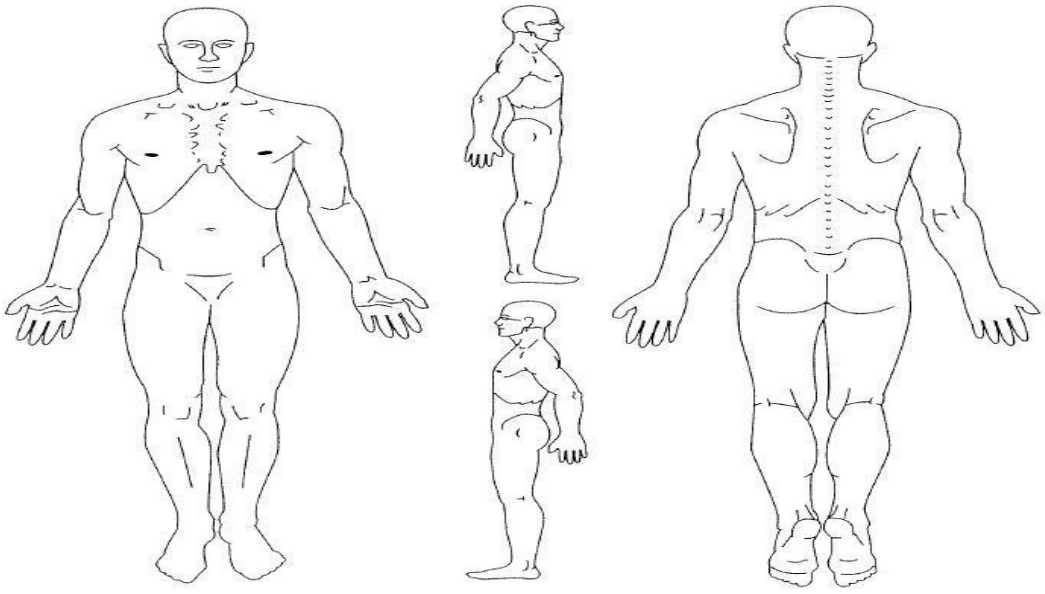
PSYCHIATRIC:
__Alzheimer's Disease
__Insomnia
__Difficulty Concentrating
__Memory loss/Confusion
__Depression
__Anxiety
__Agitation/Irritability
__Suicidal Thoughts
__Chemical Dependency
__Other: _____

CARDIOVASCULAR:
__Chest Pain
__Heart Attack
__Shortness of Breath
__Palpitations
__Swelling of feet/hands
__High Blood Pressure
__High Cholesterol
__Heart Murmur
__Blood Clots
__Pacemaker
__Mitral Valve Prolapse

ENDOCRINE:
__Diabetes
__Thyroid Disease
__Sweating
__Heat Intolerant
__Cold Intolerant
__Weight Loss
__Weight Gain
__Frequent Urination
__Excessive Thirst
__Change in Appetite
__Hair Changes
__Other: _____

Please list all current medications being taken _____
_____
_____

By Using the key below, mark where you have pain or other symptoms:
N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache P=Pain



Primary Complaint: _____

Secondary Complaint: _____

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 make it feel better? Yes No **If Yes, please list:**_____

What makes it worse? _____

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

Date Problem Began: _____ **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 _____

Does the pain travel/Radiate anywhere? Yes No **If yes, please describe:** _____

_____

Since the problem began is it: __Same __Getting Better __Getting Worse

FRAZETTA FAMILY CHIROPRACTIC

PAYMENT POLICY

Thank you for choosing Frazetta Family Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to call you 15 minutes after your scheduled time. If you do not show and we do not hear from you in a few days, we will send you a postcard. We are now offering email and text appointment reminders to help our patients keep their appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**