



CONFIDENTIAL HEALTH INFORMATION

Frisina Family Wellness Center
1533 S. MacArthur Blvd.
Springfield, IL 62704
217-787-4345
www.frisinafamilychiropractic.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)	Have you consulted a chiropractor before? <input type="radio"/> No <input type="radio"/> Yes When? _____	Patient Number (office use only)	
Whom may we thank for referring you?		If so, whom?	
Your Last Name	Your Social Security Number	Birth Date (MM/DD/YYYY)	Age
Your First Name	Your Middle Name (or Initial)	Gender <input type="radio"/> Male <input type="radio"/> Female	Race
Address	Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated		Ethnicity
City	State/Province	ZIP/Postal Code	Preferred Language
Home Phone	Cell Phone	Spouse's Name	
Email Address	Child's Name and Age		
Emergency Contact	Emergency Contact's Phone	Child's Name and Age	
Your Occupation	Child's Name and Age		
Your Employer	Work Phone		
Address	May we contact you at work? <input type="radio"/> Yes <input type="radio"/> No		
City	State/Province	ZIP/Postal Code	Preferred method of contact? <input type="radio"/> Home Phone <input type="radio"/> Cell Phone <input type="radio"/> Work Phone <input type="radio"/> Email
Primary Care Provider's Name			
Insurance Carrier	Policy Number	Group Number	
Insured's Last Name	Birth Date (MM/DD/YYYY)	Who carries this policy? <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent	
Insured's First Name	Insured's Middle Name (or Initial)		
Insured's Employer			
Address			
City	State/Province	ZIP/Postal Code	Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?)

4. Intensity (How extreme are your current symptoms?)



5. Duration and Timing (When did it start and how often do you feel it?)

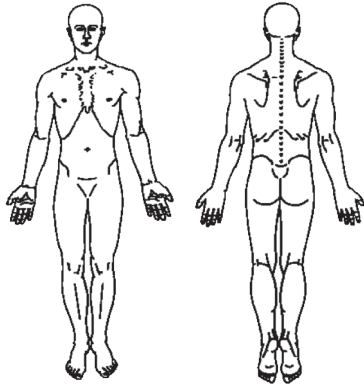
Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)

Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Frisina Family Wellness Center know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- | | | | | | | |
|---|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Osteoporosis | Had <input type="radio"/> Have <input type="radio"/> Arthritis | Had <input type="radio"/> Have <input type="radio"/> Scoliosis | Had <input type="radio"/> Have <input type="radio"/> Neck pain | Had <input type="radio"/> Have <input type="radio"/> Back problems | Had <input type="radio"/> Have <input type="radio"/> Hip disorders | NONE <input type="radio"/> |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | Initials _____ |

b. Neurological

- | | | | | | | |
|--|---|---|--|---|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Anxiety | Had <input type="radio"/> Have <input type="radio"/> Depression | Had <input type="radio"/> Have <input type="radio"/> Headache | Had <input type="radio"/> Have <input type="radio"/> Dizziness | Had <input type="radio"/> Have <input type="radio"/> Pins and needles | Had <input type="radio"/> Have <input type="radio"/> Numbness | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

c. Cardiovascular

- | | | | | | | |
|--|---|---|---|---|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> High blood pressure | Had <input type="radio"/> Have <input type="radio"/> Low blood pressure | Had <input type="radio"/> Have <input type="radio"/> High cholesterol | Had <input type="radio"/> Have <input type="radio"/> Poor circulation | Had <input type="radio"/> Have <input type="radio"/> Angina | Had <input type="radio"/> Have <input type="radio"/> Excessive bruising | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

d. Respiratory

- | | | | | | | |
|---|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Asthma | Had <input type="radio"/> Have <input type="radio"/> Apnea | Had <input type="radio"/> Have <input type="radio"/> Emphysema | Had <input type="radio"/> Have <input type="radio"/> Hay fever | Had <input type="radio"/> Have <input type="radio"/> Shortness of breath | Had <input type="radio"/> Have <input type="radio"/> Pneumonia | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

e. Digestive

- | | | | | | | |
|---|--|---|--|---|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Anorexia/bulimia | Had <input type="radio"/> Have <input type="radio"/> Ulcer | Had <input type="radio"/> Have <input type="radio"/> Food sensitivities | Had <input type="radio"/> Have <input type="radio"/> Heartburn | Had <input type="radio"/> Have <input type="radio"/> Constipation | Had <input type="radio"/> Have <input type="radio"/> Diarrhea | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

f. Sensory

- | | | | | | | |
|---|--|---|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Blurred vision | Had <input type="radio"/> Have <input type="radio"/> Ringing in ears | Had <input type="radio"/> Have <input type="radio"/> Hearing loss | Had <input type="radio"/> Have <input type="radio"/> Chronic ear infection | Had <input type="radio"/> Have <input type="radio"/> Loss of smell | Had <input type="radio"/> Have <input type="radio"/> Loss of taste | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

g. Skin

- | | | | | | | |
|--|--|---|---|--|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Skin cancer | Had <input type="radio"/> Have <input type="radio"/> Psoriasis | Had <input type="radio"/> Have <input type="radio"/> Eczema | Had <input type="radio"/> Have <input type="radio"/> Acne | Had <input type="radio"/> Have <input type="radio"/> Hair loss | Had <input type="radio"/> Have <input type="radio"/> Rash | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

Patient name _____

Patient Number (office use only) _____

Consultation Notes

Doctor's Initials _____

Frisina Family Wellness Center

(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE

Patient name _____

Initials _____

Patient Number (office use only) _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL	14. Illnesses Check the illnesses you have Had in the past or Have now.	15. Operations Surgical interventions, which may or may not have included hospitalization.	16. Treatments Check the ones you've received in the Past or are receiving Currently .
	Had <input type="radio"/> Have <input type="radio"/> AIDS Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	<input type="radio"/> Appendix removal	Past Currently
	<input type="radio"/> Alcoholism <input type="radio"/> Typhoid fever	<input type="radio"/> Bypass surgery	<input type="radio"/> Acupuncture
	<input type="radio"/> Allergies <input type="radio"/> Ulcer	<input type="radio"/> Cancer	<input type="radio"/> Antibiotics
	<input type="radio"/> Arteriosclerosis <input type="radio"/> Allergies to medications and the reactions (Please List)	<input type="radio"/> Cosmetic surgery	<input type="radio"/> Birth control pills
	<input type="radio"/> Chicken pox _____	<input type="radio"/> Elective surgery: _____	<input type="radio"/> Blood transfusions
	<input type="radio"/> Diabetes _____	<input type="radio"/> Eye surgery _____	<input type="radio"/> Chemotherapy
	<input type="radio"/> Epilepsy _____	<input type="radio"/> Hysterectomy _____	<input type="radio"/> Chiropractic care
	<input type="radio"/> Glaucoma <input type="radio"/> Other: _____	<input type="radio"/> Pacemaker _____	<input type="radio"/> Dialysis
	<input type="radio"/> Goiter _____	<input type="radio"/> Spine _____	<input type="radio"/> Herbs
<input type="radio"/> Gout _____	_____	<input type="radio"/> Homeopathy	
<input type="radio"/> Heart disease _____	<input type="radio"/> Tonsillectomy _____	<input type="radio"/> Hormone replacement	
<input type="radio"/> Hepatitis _____	<input type="radio"/> Vasectomy _____	<input type="radio"/> Inhaler	
<input type="radio"/> HIV Positive _____	<input type="radio"/> Other: _____	<input type="radio"/> Massage therapy	
<input type="radio"/> Malaria _____	_____	<input type="radio"/> Physical therapy	
<input type="radio"/> Measles _____	_____	<input type="radio"/> Nutritional supplements: _____	
<input type="radio"/> Multiple Sclerosis _____	_____	List: _____	
<input type="radio"/> Mumps _____	_____	_____	
<input type="radio"/> Polio _____	17. Injuries Have you ever...	<input type="radio"/> Medications (prescription and over-the-counter): _____	
<input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
<input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
<input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
<input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Frisina Family Wellness Center about the health of your immediate family members.

	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
FAMILY	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Frisina Family Wellness Center about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials _____

Frisina Family Wellness Center

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only) _____

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Initials _____ **I choose to decline receipt of my clinical summary after every visit, but understand that I may request this summary at any time. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)**

If the patient is a minor child, print child's full name: _____

Consultation Notes

Doctor's Initials _____

Frisina Family Wellness Center

Signature _____

Date (MM/DD/YYYY) _____