Frazetta Family Chiropractic
New Patient Intake Form

Date: ____________

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 Name: ___________________________

REFERRAL INFORMATION

How did you hear about our office? Website FaceBook Drive By Patient

Name of patient who referred you: ____

PCP INFORMATION

Physician Name: ______________________ Phone: ______________________

Do you give Frazetta Family Chiropractic permission to discuss your condition with your PCP?
YES / NO Location: ___________________

EMPLOYER INFORMATION

Employment Status: Employed Unemployed FT Student PT Student Other____

Your Occupation ____

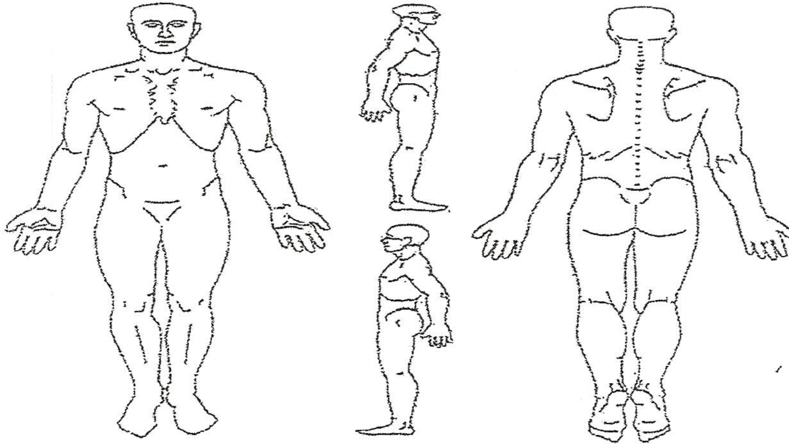
EMERGENCY CONTACT

Contact Name _______________________ Relationship to Patient _______________

Contact Home Phone (____) _______-________ Cell Phone (____) _______-___________

NAME: ____ AGE: ____________

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
- Burning
- Ache
- Tingling
- Numb
- Throbbing
- Shooting
- Other ______

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

____

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

NAME: ______________________________ AGE: __________

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	Yes / No	If Yes – How Much: ______	
Cigarettes:	Yes / No	If Yes – How Much: ______	
Sleep:	Do you sleep 8 hours a night? Yes / No		

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: ______________________________

Have you ever been hospitalized? Yes / No If Yes, please list dates and details: __________

____

____

Have you had any surgeries? Yes / No If Yes, please list dates and details: __________

____

____

Do you take any Medications? Yes / No

Please list all medications and dosages (how much & how often): ______________________

____

____

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

GENERAL

- NO PROBLEMS
- Lethargy / Weakness
- Recurring Fever
- Recent weight loss or gain
- Dizziness
- Fever
- Chills

OTHER ________________

RESPIRATORY

- NO PROBLEMS
- Persistent cough
- Spitting up blood
- Asthma or wheezing
- Exercise intolerance
- Sleep apnea
- Emphysema
- Snoring issues
- Pneumonia

OTHER ________________

BLOOD / LYMPH

- NO PROBLEMS
- Anemia
- Bleeding
- Bruising
- Blood clots
- Past transfusions
- Leukemia
- Lymphoma
- HIV/AIDS
- Sickle cell

OTHER ________________

PSYCHIATRIC

- NO PROBLEMS
- Alzheimer's Disease
- Insomnia
- Difficulty concentrating
- Memory loss/confusion
- Depression
- Anxiety
- Agitation/Irritability
- Suicidal thoughts
- Chemical dependency

OTHER ________________

EARS, NOSE, MOUTH, & THROAT

- NO PROBLEMS
- Eye or vision problems
- Eyeglasses or contact lenses
- Nose bleeds
- Cataracts
- Glaucoma
- Swollen glands
- Ear or hearing problems
- Dental problems
- Gum problems
- TMJ problems

OTHER ________________

GASTROINTESTINAL

- NO PROBLEMS
- Loss of appetite
- Nausea or vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Stomach ulcer
- Bloating/Cramping
- Hemorrhoids
- Hepatitis
- Cirrhosis
- Difficulty swallowing
- Liver disease
- Gallbladder problems
- Pancreatitis
- Black or bloody stool
- Colon cancer or colon polyps
- Irritable bowel syndrome
- Crohn's disease
- Gastric reflux
- Colitis

OTHER ________________

ALLERGIES

- NO PROBLEMS
- Seasonal
- Medication
- Food

OTHER ________________

SKIN / HAIR

- NO PROBLEMS
- Skin trouble or rashes
- Flushing
- Excessive acne
- Eczema
- Psoriasis
- Skin cancer
- Change in hair or nails

OTHER ________________

NEUROLOGICAL

- NO PROBLEMS
- Frequent headaches
- Migraines
- Dizziness
- Fainting
- Memory loss
- Poor balance
- Epilepsy or seizures
- Stroke
- Tremors
- Head injury
- Anxiety and/or panic
- Depression
- Sleeping issues
- Loss of smell or taste
- Difficulty concentrating

OTHER ________________

MALE

- NO PROBLEMS
- Painful or frequent urination
- Incontinence
- Prostate Disease
- Erectile Dysfunction
- Blood in urine
- Urinary infections
- Testicular pain or lumps

OTHER ________________

CARDIOVASCULAR

- NO PROBLEMS
- Chest pain or tightness
- Heart attack
- Shortness of breath
- Palpitations
- Swelling of feet or hands
- High blood pressure
- High cholesterol or triglycerides
- Heart murmur
- Blood clots
- Pacemaker
- Mitral valve prolapse
- Congenital heart defects
- Rheumatic fever
- Varicose veins
- Coronary artery disease

OTHER ________________

MUSCULOSKELETAL

- NO PROBLEMS
- Fractures
- Implants, plates, pins or screws
- Gout

OTHER ________________

FEMALE

- NO PROBLEMS
- Painful Sex
- Urinary Infections
- Breast Pain or Lumps
- Hot Flashes
- Menstrual Irregularity
- Bladder or Urinary Complaints
- Menopause
- Sexually Transmitted Disease

OTHER ________________

ASSIGNMENT OF BENEFITS / INFORMED CONSENT / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility
I have requested professional services from **Frazetta Family Chiropractic,** 846 Pittsburgh Street, Springdale, PA 15144 ("Sebastian J. Frazetta, D.C.") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Informed Consent for Treatment
I understand, as with any healthcare procedures, that there are certain complications, which may arise during chiropractic treatments including but not limited to; fractur, disc injury, strokes, dislocations and sprains. The risks of complications have been described as rare. The cerebra vascular injury is estimated as one in one million to one in twenty million. You can ask the doctor of other treatment options which could be considered. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

____________________________ ______________
Print Full Name *Date*

____________________________ ______________
Patient Signature *Date*

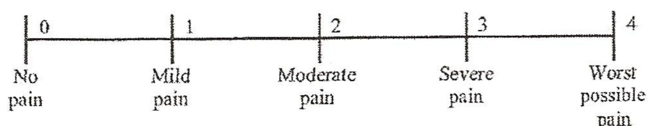
____________________________ ______________
Policyholder/Insured Signature *Date*

Functional Rating Index

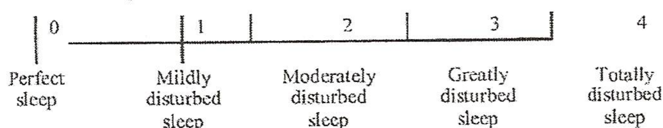
For use with **neck and/or back problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

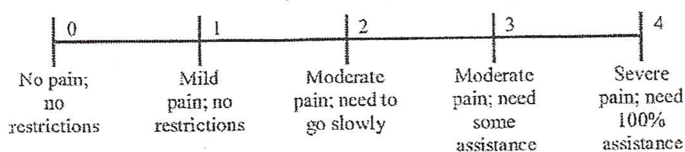
1. Pain Intensity



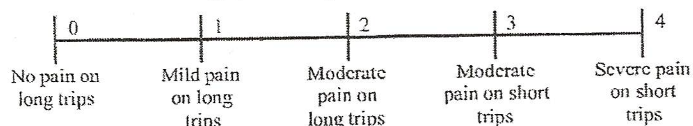
2. Sleeping



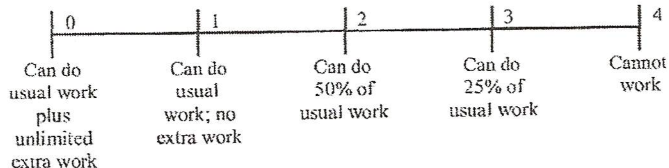
3. Personal Care (washing, dressing, etc.)



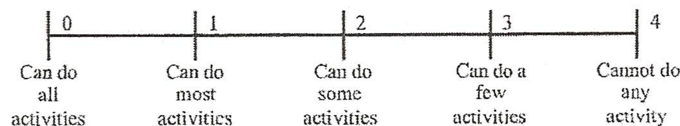
4. Travelling (driving, etc.)



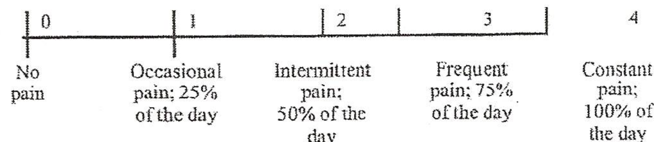
5. Work



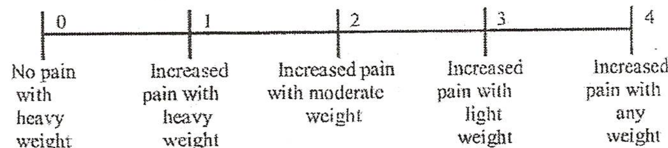
6. Recreation



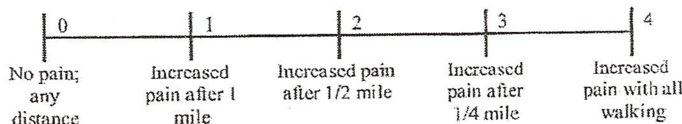
7. Frequency of Pain



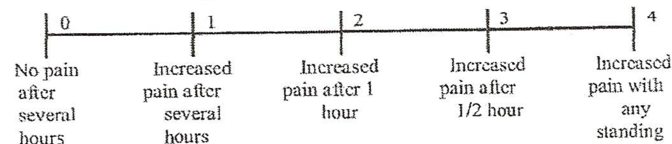
8. Lifting



9. Walking



10. Standing



______________________________ Patient's Signature

____________________ Date

For Office Use Only:

Practitioner ID#: ________________________

Total Score ______________ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: ________________________