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

Referral Information

How did you hear about our office? Website Facebook Driving By Patient

Name of patient who referred you_____

Employer Information

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

Employer _____

Your Occupation _____

PCP Information

Physician Name: _____ Phone Number:_____

Do you give Frazetta Family Chiropractic permission to discuss you condition with your PCP: yes/ no

Emergency Contact

Contact Name _____ Relationship to Patient _____

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

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: □ <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_____

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 If Yes, please list medications, dosage and how often taken

_____

_____

Women:

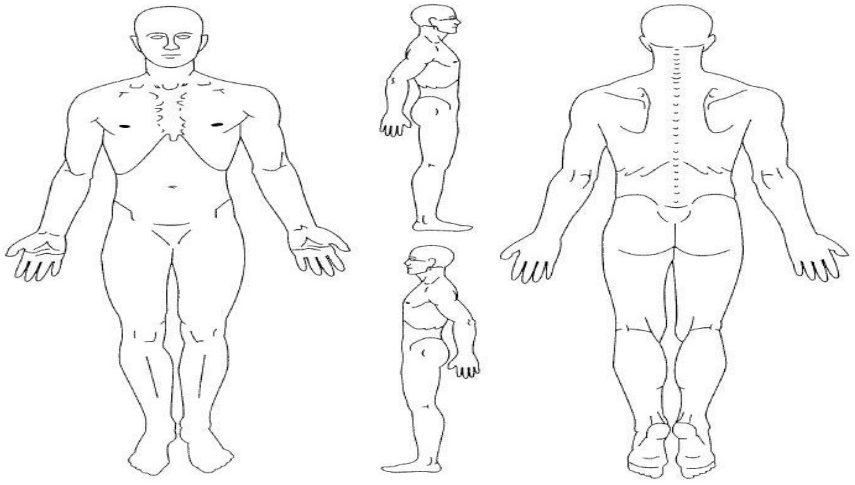
How many children do you have? _____ **Are you pregnant?** _____ **Are you nursing?** _____

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

Patient Name_____**Date**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



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 improve your pain? Yes No If Yes, please list:_____

What makes your pain worse? _____

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

Date your symptoms 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? _____

Since the problem began it is: _____**Same** ____**Getting Better** ___**Getting better** ____**Getting worse**

Review of Systems

General

__No problems
__Lethargy/weakness
__Recurring Fever
__Recent weight gain/loss
__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
__Insomnia
__Difficulty concentrating
__Memory loss/confusion
__Depression
__Anxiety
__Agitation/Irritability
__Suicidal Thoughts
__Chemical Dependency

Ears, nose, throat

__No problems
__Eye or vision problems
__Eyeglasses/contacts
__Nose bleeds
__Cataracts
__Glaucoma
__Swollen glands
__Ear/hearing problems
__Dental problems
__Gum problems
__TMJ problems

Gastrointestinal

__No problems
__Loss of appetite
__Nausea or vomiting
__Diarrhea
__Constipation
__Abdominal pain
__Stomach ulcer
__Bloating/cramping
__Hepatitis
__Cirrhosis
__Difficulty swallowing
__Liver disease
__Gallbladder problems
__Pancreatitis
__Black or bloody stool
__Colon cancer or polyps
__Irritable bowel syn.
__Crohn's disease
__Gastric reflux
__Colitis
__Other_____

Allergies

__No problems
__Seasonal
__Medications
__Food
__Other_____

Skin/Hair

__No problems
__Skin trouble/rash
__Flushing
__Excessive acne
__Eczema
__Psoriasis
__Skin cancer
__Change in hair/nails
__Other_____

Neurological

__No problems
__Frequent headaches
__Migraine
__Dizziness
__Fainting
__Memory loss
__Poor balance
__Epilepsy or seizures
__Stroke
__Tremors
__Head injury
__Anxiety and/or panic
__Depression
__Sleep issues
__Loss of smell/taste
__difficulty concentrating
__Other_____

Male

__No problems
__Painful or frequent urination
__Incontinence
__Prostate Disease
__Erectile Dysfunction
__Blood in urine
__Urinary infection
__Testicular pain or lumps
__Sexually Transmitted Disease
__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 Infection
__Chest pain or lumps
__Hot flashes
__Menstrual irregularity
__Bladder or Urinary complaints
__Menopause
__Sexually Transmitted Disease
__Other_____

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 problem has affected our ability to manage everyday activities. For each item below, please circle the number which most clearly describes your condition right now.

1 Pain Intensity

0---------1---------2---------3---------4

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2 Sleeping

0---------1---------2---------3---------4

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3 Personal Care (washing, dressing, etc.)

0---------1---------2---------3---------4

No pain no restriction	Mild pain; no restriction	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4 Traveling (driving, etc.)

0---------1---------2---------3---------4

No Pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5 Work

0---------1---------2---------3---------4

Can do Usual Work + Unlimited Extra work	Can do usual work (no extra work)	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6 Recreation

0---------1---------2---------3---------4

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7 Frequency of Pain

0---------1---------2---------3---------4

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain, 75% of the day	Constant pain; 100% of the day

8 Lifting

0---------1---------2---------3---------4

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9 Walking

0---------1---------2---------3---------4

No pain any distance	Increases pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10 Standing

0---------1---------2---------3---------4

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

_____ _____

Patient's Signature **Date**

For office use only:
Practioner ID#_____
Total Score_____/40

Clinical Diagnosis Code:
patient ID#_____

ASSIGNMENT OF BENEFITS / INFORMED CONSENT / ERISA AUTHORIZED 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 that incurred during the course of said services. I understand that all fees for said service are due and payable on the date the service is rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement, unless other arrangements have bee 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 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 pain 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 procedure, that there are certain complications, which may arise during chiropractic treatments, including but not limited to; fracture, disc injury, stroke, dislocation and sprains. The risks of complications have been described as rare. The cerebra vascular injury is estimated as 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 judgement 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 benefits plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (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 benefits 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 provision of ERISA as provided for 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 the Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Print Full Name **Date**

_____ _____

Patient Signature **Date**

_____ _____

Policyholder/Insured Signature **Date**