



NORTH PLAZA
 SHOPPING CENTER
 8838 WALTHAM WOODS ROAD
 BALTIMORE, MARYLAND 21234
 (410) 668-4000

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

THANK YOU.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ E-mail _____ Who referred you to our office? _____
 (Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Employer _____ Location _____

Nearest relative and contact number: _____

HEALTH INFORMATION:

Have you had previous chiropractic care? _____

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

What improves your condition? _____

Is the problem constant? It comes and goes Is this condition getting progressively worse? Yes No

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Type of care desired: Temporary pain relief Corrective care

How long has it been since you really felt good? _____

Other doctors who treated this condition _____

Do you have a primary medical physician: No Yes Name _____ Phone # _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills Tranquilizers
 Insulin Birth control pills Others _____

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Have you ever been in an auto accident? Past year Past 5 years Over 5 years Never

If yes, describe: _____

Have you had any other personal injury? Past year Past 5 years Over 5 years Never

If yes, describe: _____

HEALTH HISTORY:

Please indicate for each of the questions below your experience by use of the following codes: if presently have or month/date if previously had

MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

NERVOUS SYSTEM

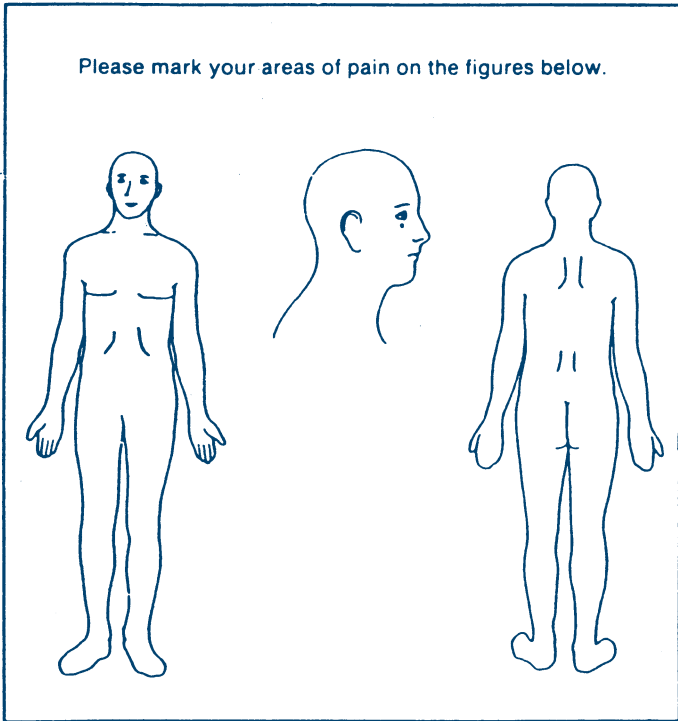
- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

CARDIO-VASCULAR-RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose Veins

EYE, EAR, NOSE, AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear Discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech



FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

WORKERS COMPENSATION QUESTIONNAIRE

(IF APPLICABLE)

Please explain in detail how your accident happened _____

Give time and date present injury occurred _____ AM PM _____ 20_____

Did you feel pain immediately after the accident? Yes No Where? _____

Did you return to work? Yes No If so, date returned to work _____

Have you ever injured this area before? Yes No if so, when? _____

If injured before, did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

Do any other diseases or accidents affect your employment? Yes No If so, explain _____

In your work do you have to favor any part of your body? Yes No If so, explain _____

Do you have a history of absenteeism caused from accidents on the job? Yes No

Have you ever had a Workmen's Compensation claim before? Yes No

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since this injury are your symptoms improving? getting worse? the same?

Claim # _____ Claims Adjuster _____ Telephone # _____

AUTO ACCIDENT QUESTIONNAIRE

(IF APPLICABLE)

Please explain in detail how your accident happened _____

Insurance Co. _____ Policy No. _____ Claim No. _____

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

You were heading North East South West on _____ (street or highway)

Other vehicle was headed North East South West on _____ (street or highway)

Were police notified? Yes No

Were you knocked unconscious? Yes No If so, for how long? _____

You were struck from Behind Front Left side Right side

You were Driver Passenger Front seat Back seat Using seat belts Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since this injury are your symptoms Improving? Getting worse? Same?

Please take a moment to read over and sign/date the following:

INFORMED CONSENT

The chiropractic adjustments, physical therapy and other clinical procedures are usually beneficial and seldom cause any problem. Although the incidence of complications associated with our services is very low, anyone undergoing adjusting, physical therapy or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetected by the Doctor of Chiropractic.

Patient or Guardian _____ Date _____

INSURANCE INFORMATION:

Do you have Health Insurance? Yes No If yes, please give the receptionist your insurance card to copy.

Is your condition due to an auto accident or job related injury? Yes No

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to The Frieman Chiropractic Center the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient's Signature _____ Date _____

OFFICE POLICY

I understand and agree that health and accident policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the Insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment, which can be charged to my credit card. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Should this account be referred to an Attorney for collections the undersigned will be liable for all reasonable attorney fees and collection expenses. I also understand the 24-hour notice is required on all cancellations, and that otherwise there may be a fee for missed appointments.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

This is to certify that to the best of my knowledge I am not pregnant and the Frieman Chiropractic Center has my permission to take x-rays of me.

Patient's Signature _____ Date: _____

I hereby give my consent to the Frieman Chiropractic Center to examine, x-ray and treat my child or ward.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

* Complete Front only

SUBJECTIVE ANALYSIS
and Objective Outcome Measure Assessment

Patient Name: _____

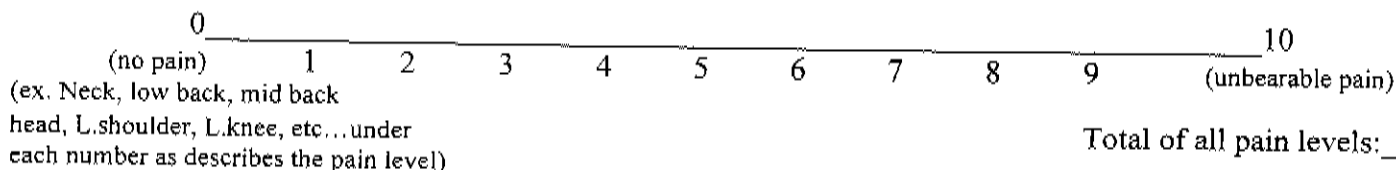
Date: _____

Attending Dr.: Robert G. Frieman D.C.

(Initial / Re-exam)

VISUAL ANALOG SCALE

(Please indicate the level you are currently experiencing by writing each involved body area on the scale below.)



Please Circle:

*Quality of pain: **Sharp / Dull / Numb / Tingling;** _____ *Are your symptoms **Better / Worse / Same** since they began

*Pain or numbness and tingling is radiating down **right arm / left arm / right leg / left leg;** *Pain is **constant / intermittent**

*What relieves your pain?: _____ What makes it worse?: _____

⇒ Date Current Complaint Began: _____ Current complaint due to: _____
(brief description)

ACTIVITIES OF DAILY LIVING

People with spinal pain may find that certain activities are restricted or difficult to do.

Check or circle all activities that you find difficult to do NOW.

- Sleep throughout the night
- Get up from a low seat
- Get out of bed
- Cross legs
- Make your bed
- Walk one mile
- Bathe yourself
- Stand for 30 minutes
- Wash, comb or dry your hair
- Travel on journeys that take over one hour
- Bend over sink for 10 minutes
- Push or pull a vacuum cleaner
- Go to the bathroom
- Carry laundry basket, groceries or small child
- Put on socks, shoes or clothing
- Wash windows or walls
- Walk up one flight of stairs
- Bend over to clean bathtub
- Walk down one flight of stairs
- Shovel snow or dirt
- Crawl on all fours
- Use pencil, scissors, screwdriver or pliers
- Turn a door knob
- Lift Heavy suitcase (about 40 pounds)
- Open a heavy door
- Reach in front or overhead to high shelves
- Sit in a chair for 30 minutes
- Enjoy hobbies or social activities
- Sit and work at a desk for one hour
- Enjoy sexual activities

Total # of ADL items checked: _____

Subjective total: _____

Check or circle any of the following conditions you are currently experiencing:

- Neck or back weakness
- Restricted movement of neck or back
- Persistent tender areas in muscles of neck or back
- "Catch" or "kink" in neck or back

Anything else you would like the Doctor to Know? No Yes _____

Patient Signature: _____ Date: _____