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

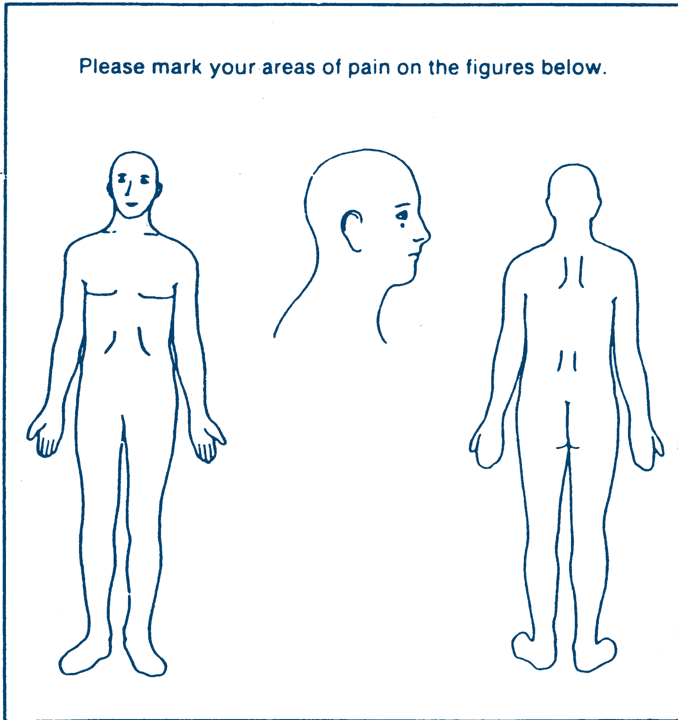
CARDIO-VASCULAR-RESPIRATORY

_____ 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

Please mark your areas of pain on the figures below.



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 occured ______________ ☐ 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. Futhermore, 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 (Initial / Re-exam)

File # __________.

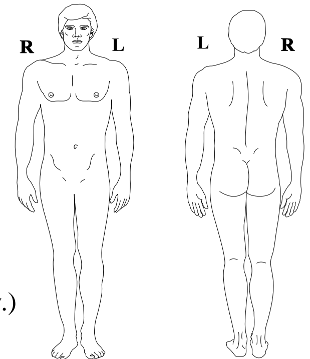
Patient Name:____ Date:_______________

Attending Dr.: Robert G. Frieman, D.C.
Sarah Barbee, D.C.

PAIN DIAGRAM

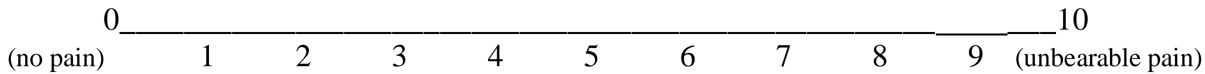
Draw these symbols on the body to the right to describe the type of pain or sensations you are feeling:

>>>	**Aching pain**	///	**Stabbing or Sharp pain**	**XXX**	**Burning pain**
===	**Numbness**	**ooo**	**Pins and Needles**		



VISUAL ANALOG SCALE

(Please indicate the level you are currently experiencing by writing each involved body area on the scale below.)
(ex. neck, low back, mid back, head, L. shoulder, L. knee, etc at each number)



Please Circle: Total of all pain levels:____

*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 of how pain started)

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

Frieman Chiropractic 8838 Waltham Woods Road; Baltimore, MD 21234; (410)-668-4000 Fax: (410) 668-6812

As you prepare for your subluxation station examination:

- Please avoid alcohol for 24 hours before the test.
- No exercise for at least 3 hours prior to the test.
- Consume only your "normal" amount of caffeine for the day, no more.
- Avoid as many medications as possible the day of the test. DO NOT STOP TAKING YOUR MEDICATIONS, this applies to over the counter medications or medications that are not time sensitive and can be taken after the test.
- Refrain from using heated car seats, icy hot back patches, heat packs, ice packs, biofreeze, etc the day of the test.
- Please arrive 10 minutes prior to your appointment time, as this is a specific and separate block of time for you.

This is a time specific appointment and while our normal policy is that you can arrive 15 minutes early or late for an adjustment appointment, we cannot offer that type of flexibility for this specific examination.

Thank you!

Drs. Frieman and Barbee