FRIEMAN CHIROPRACTIC

HEALTHCARE FOR THE ENTIRE FAMILY

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

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 _____ Personal 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? _____

Have you had this or a similar condition in the past? ☐ Yes ☐ No How long have you had this episode? _____

How did it start? _____

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: _____

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

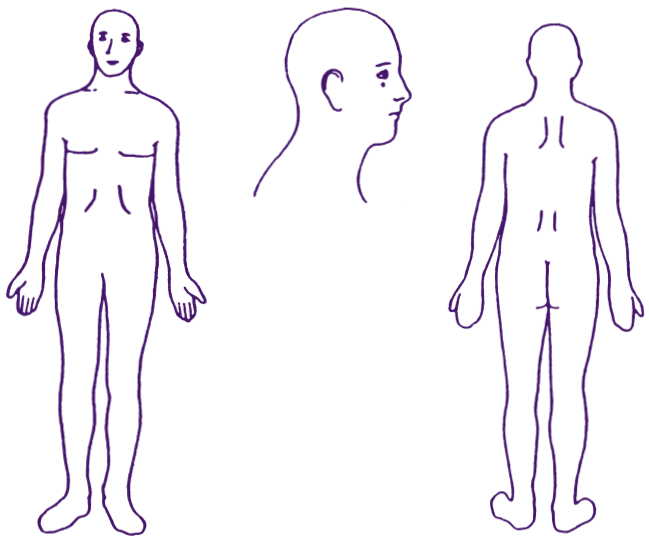
CARDIO-VASCULAR-RESPIRATORY

____ 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

PAIN DIAGRAM



Draw these symbols on the body 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		

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. 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.

Guardian or Parent Signature: _____ Date: _____

INITIAL SUBJECTIVE ANALYSIS File #_____

Patient Name: _____ Date: _____

Attending Doctor: Robert G. Frieman, D.C. / Sarah Barbee, D.C. / Andrew R. Rill, D.C.

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., written above the number associated with the level)

0_____10

(no pain) 1 2 3 4 5 6 7 8 9 (unbearable pain)

Total of all pain levels:_____

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.

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

Total # of ADL items checked: _____

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: _____

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