Frankum Chiropractic

Demographic Information

Patient Legal Name: First: _____ Middle Initial: _____ Last: _____

Nickname, "I prefer to be addressed as":_____ How did you hear about Frankum Chiropractic?_____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: _____ Email: _____

By providing my email address, I authorize my doctor to contact me via the email address provided

Social Security Number: _____ Marital Status: _____ Spouse Name:_____

Employment Status: □Employed □Full time student □Part time student □_____ Employer: _____

Employer Address:_____ City: _____ State: _____ Zip: _____

Job Title:_____ Type of Work:_____

Emergency Contact Name: _____ Emergency Contact Phone: _____

FAMILY HISTORY

Does anyone in your family have a history of (please list relation in the blank beside the condition)?

❑Arthritis_____ ❑Diabetes_____ ❑Cholesterol_____
❑Cancer_____ ❑Thyroid_____ ❑Psychiatric_____
❑Cardiovascular Problems: _____ ❑Stroke_____ ❑ Other:_____

Patient's Health and Social History and Review of Systems

Recreational Activities:_____
Alcohol Frequency of Use:_____
Substance Use:_____

List Children's Names and Ages
*_____ *_____ *_____
*_____ *_____ *_____

Current medications (Use back of sheet if necessary)

No current medications, check here: ❑

Medication Name	Frequency	Dosage	Start Date	What is medication being taken for

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

_____

Briefly list your main health problems:

_____
_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe:_____
Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

Please list ALL surgeries and dates:_____
_____

Have you ever seen a massage therapist? ❑ Yes ❑ No When?_____ Who?_____

Are you pregnant? ❑ Yes ❑ No ❑N/A Due Date:_____

Print Patient Name:_____ Patient/Parent/Guardian Signature:_____ Date:_____

Frankum Chiropractic

Massage Therapy
History of Present Illness

Briefly describe why you are here today:_____

_____

_____

Have you had any of the following symptoms in the past 60 days? ❑ NO

❑ Numbness/Tingling	❑ Lightheaded	❑Chest Pain/Discomfort	❑Confusion
❑Headaches	❑Dizziness	❑Shortness of Breath	❑Trouble Speaking
❑Changes in vision	❑Nausea/Vomiting	❑Skin Rashes	❑ Change in bladder/bowel function
❑Numbness in groin	❑Muscle Weakness	❑Fever	❑Trouble Sleeping

Have you ever received professional massage work before? ❑Yes ❑No If yes, when?_____ and where?_____

What kind of pressure do you prefer? ❑Light ❑Medium ❑Firm

Are you wearing any of the following today? ❑ contacts ❑dentures ❑ hairpiece

Are you pregnant? ❑Yes ❑No ❑N/A If yes, when is your due date?_____
Is this a high risk pregnancy: ❑Yes ❑No ❑N/A
Have you had any problems with your pregnancy" ❑Yes ❑No ❑N/A

Have you had any injuries or surgeries in the past that may influence today's treatment? ❑Yes ❑No
If yes, please explain:_____

Do you have or have you had any of the following conditions?

❑Bruise Easily	❑DVT	❑Varicose Veins	❑Swelling
❑Sensitive to touch/pressure	❑High Blood Pressure	❑Low Blood Pressure	❑Stroke
❑Heart Attack	❑Cancer	❑Neurological (MS, Parkinson's)	❑Epilespsy/Seizures
❑Digestive Conditions	❑Kidney Disease	❑Osteoporosis	❑Scoliosis
❑Broken Bones	❑Allergies	❑Diabetes	❑Depression/Anxiety
❑Fibromyalgia	❑Rheumatoid Arthritis	❑_____	

Is there anything else we need to know prior to you appointment:_____

_____

_____

Print Patient Name:_____

Patient/Parent/Guardian Signature:_____

Date:_____