

Welcome to our office. We strive to provide the best possible care.
If you have any questions, please ask.

About you:

First name: _____ Last name: _____ Middle initial: _____
What you prefer to be called: _____ male female Social Security: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Work/Cell phone: _____
E-mail: _____ May we email you about appointments, clinic information, billing, etc? Y N
Date of Birth: ____/____/____ Occupation: _____ Employer: _____
Work Address: _____
Marital Status: M S D W Significant Others Name: _____
Emergency Contact: _____ Phone: _____

My pain is the result of:

Auto accident that occurred on __/__/__ Work Injury that occurred on __/__/__
 Sports or other trauma Chronic condition Other: _____

Method of Payment: Cash Credit Card Check Insurance Other _____

Insurance Company: _____ Name of insured: _____

Insurance Address/phone: _____

Birthdate: _____ Social Security # _____ Employer: _____

Policy#: _____ Group#: _____

Deductible: _____ Amount met: _____ Copay: _____

Secondary Insurance Company: _____ Name of insured: _____

Insurance Address/phone: _____

Birthdate: _____ Social Security # _____ Employer: _____

If Auto accident:

You Insurance company, Policy #, Adjuster name & Telephone #:

Other Insurance company, Policy #, Adjuster name & Telephone #:

Application For Admission

Non Surgical Disc Treatment Program

Although you are here for a *consultation* with Frye Chiropractic, Inc,
it does NOT mean that your case has been accepted.

Your consultation today will determine if:

A) You are a legitimate candidate for this program and B) Your condition is serious enough to warrant your case being accepted for treatment. In the event your condition IS serious enough to warrant being considered for acceptance into the Non-Surgical Disc Treatment Center

Today's Date _____

Name _____ Age _____ Birthday _____ Sex M F

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No

Employer _____ Occupation _____ Length of Employment _____

SS# _____ Marital Status S M W D Spouses Name _____

I (signature) _____ consent to allow Frye Chiropractic to review my history and perform an examination (if necessary) in order to determine if I am a good candidate for non-surgical spinal decompression and also to determine if I qualify for the program.

How did you hear about our program? _____

How Serious Do You Think Your Problem Is? _____

What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?

Would You Consider This Problem(circle one).... MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

Patient: Harry Engel 404 **Date:** 02/10/11

2. What are you hoping happens today as a result of your consultation with the Doctor?

3. Since your back pain became this severe, what three things has it caused you to miss **the most**? *Please Answer*

1-----
2-----
3-----

4. How long have you been like this?

5. How has your life changed since your back became a problem?

6. What activities are you limited in?

7. What kinds of treatments have you received?

Epidural:	How Many _____	When(approx) _____	
Physical Therapy:	How Long _____	When(approx) _____	
Medication:	_____	_____	_____
Surgery:	Type _____	When(approx) _____	Surgeon: _____
Chiropractic:	Relief? _____	When(approx) _____	
Other _____			
Name of primary care physician: _____		Specialist: _____	

8. Did any of these treatments work? If so, which one(s) worked the best? For how long?

9. Is there anything you can do that makes it feel better?

10. What activities/movements are guaranteed to make it worse?

11. Please describe the quality of the pain. (Sharp, Dull, achy, toothache-like, shooting, stabbing, numb, tingling, etc...)

12. Is it worse in the morning, during the day, or at night?

13. If you cannot find a solution to this problem, what do you think will happen to you?

14. What are you hoping we would tell you today?

15. Describe what you hope or think we may be able to do for you.

16. Describe what will be different in your life if you can get better.

17. When is the VERY FIRST time you recall having this problem and what do you think was the cause of it?

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1. _____ How Long Have You Had This? _____
2. _____ How Long Have You Had This? _____
3. _____ How Long Have You Had This? _____
4. _____ How Long Have You Had This? _____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (check one)

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes / No How many days/weeks/months _____

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Chores/Tasks At Home? Yes / No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Family? Yes / No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...) Yes / No

How Much Time and What Tasks Have Been Limited? _____

Considering the amount of pain/discomfort you've had THIS week, has your problem been getting more severe?

On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...

The HIGHEST your pain gets WITHOUT medication _____

The LOWEST your pain gets WITHOUT medication _____

The HIGHEST your pain gets WITH medication _____

The LOWEST your pain gets WITH medication _____

List ANY surgeries that you have had and the corresponding dates.

Have you had ANY of the following in the last 12 months or currently.(Mark "C" for Current. "X" for in last 12 mos.)

GENERAL

Chills ___ Convulsions ___ Dizziness ___ Fainting ___ Fatigue ___ Fever ___ Headache ___ Loss of Sleep ___
Allergy ___ (to what _____) Loss of Weight ___ Nervousness ___ Wheezing ___ Bronchitis ___
Numbness in BOTH hands AND feet ___

CARDIOVASCULAR

High Blood Pressure ___ Low Blood Pressure ___ Pain over heart ___ Poor Circulation ___ Rapid Heartbeat ___
Previous Heart Problem ___ (Describe _____) Slow Heartbeat ___ Stroke ___ TIA ___
Swollen Ankles ___ Varicose Veins ___ Aortic Aneurysm ___ Bruise Easily ___

DISEASES/CONDITIONS

Appendicitis ___ Anemia ___ Arthritis ___ Alcoholism ___ Abdominal Surgery ___ Bleeding Disorder ___
Blood Clot(s) ___ Breathing Difficulty ___ Cancer ___ Cholesterol High ___ Colon Problems ___ Diabetes ___
Depression ___ Epilepsy ___ Eczema ___ Eating Disorder ___ Glaucoma ___ HIV + ___ Heart Disease ___
Hernia ___ Headaches ___ Influenza ___ Kidney Disease ___ Liver Disease ___ Low back Pain ___
Mental Illness ___ Measles ___ Mumps ___ Pleurisy ___ Pneumonia ___ Polio ___ Prostate Problems ___
Hyperthyroid ___ Hypothyroid ___ Rectal Surgery ___

EARS/EYES/NOSE/THROAT

Asthma ___ Crossed Eyes ___ Double Vision ___ Blurred Vision ___ Difficulty Swallowing ___ Deafness ___
Hearing Loss ___ Ear Pain ___ Thyroid Problem ___ Nose Bleeds ___ Sinus Problems ___ Sore Throats ___

GASTRO-INTESTINAL

Gas ___ Colon Trouble ___ Constipation ___ Diarrhea ___ Gallbladder Trouble ___ Hemorrhoids ___
Liver Trouble ___ Nausea ___ Stomach Ache ___ Poor Appetite ___ Poor Digestion ___ Vomiting ___
Vomiting Blood ___ Rectal Bleeding ___ Bloating ___

GENITO-URINARY

Blood in Urine ___ Frequent Urination ___ Inability to control urine ___ Kidney Infection ___ Painful Urination ___
Prostate Trouble ___ Painful Urination ___

FOR MEN ONLY

Lump in testicles ___ Penis discharge ___

FOR WOMEN ONLY

Menstrual Cramps ___ Excessive menstrual flow ___ Hot Flashes ___ Irregular Cycle ___ Painful periods ___
Birth Control Pills ___ Abnormal Pap Smear ___

MUSCLE/JOINT/BONE

Backache ___ Foot Trouble ___ Pain Between Shoulders ___ Painful Tailbone ___ Stiff Neck ___
Spinal Curvature ___ Swollen Joints ___

NEUROLOGIC

Seizures ___ Dizziness ___ Hand Trembling ___ Weakness ___ Difficulty with speech ___ Loss of memory ___
Loss of coordination ___

RESPIRATORY

Chest Pain ___ Chronic Cough ___ Difficulty Breathing ___ Coughing/Spitting Blood ___

Patient: Harry Engel 404 **Date:** 02/10/11