Dr. Fry's Chiropractic Office

Putting the pieces of the puzzle together
for your Health and Wellness.

New Patient Health History Form

Today's Date: _________

PATIENT INFORMATION

Name: (Last, First MI)____________________________________ **Preferred Name**: __________________

Address:_________________________________**City:**______________________ **State:**____ **Zip:**__________

Mobile #: __________________ **Home #:**______________________**Email:**____________________________

Gender: M / F **Marital Status:** Married / Other / Single

Social Security #: _______________ **Date of Birth:**_____________________

Student Status: Full Student / Part Student/ Non-Student / Employed/ Employer/Unemployed

Occupation: ______________________________ **Referred By:**_______________________

Race: White/African Am/Am Indian or Alaskan Native/ Native Hawaii or Pacific Island/Other

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EMERGENCY CONTACT INFORMATION

Full Name: ____

Home: ____________________ **Mobile**:_________________________

Relationship: Child / Parent / Spouse /Other: _______________________

FINANCIAL INFORMATION

☐ Insurance ☐ Self Pay (cash) ☐ Workers Comp ☐ Auto Accident ☐ Other:_________

Primary Insurance

Insurance Company:_____________

Policy #__________________________

Secondary Insurance

Insurance Company:__________________

Policy # ______________________________

Tertiary Insurance

Insurance Company:_______________

Policy #__________________________

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint:____

Began When?___ /___ /_____

Describe how this began:

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other

How frequent is the complaint present? Off & On /Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe)

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other:_________________________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other:

On a scale of 1-10, what would you rate the pain level? ____________

Received any other treatment? None / Chiro / MD / PT / Massage / ER/ Other: Where? _____

Had any previous Surgery or Interventions in this area? (Describe)

____

Taken any Medications? OTC / Prescriptions

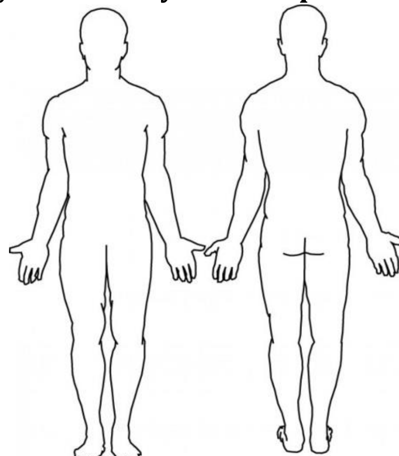
Had any diagnostic testing? X-rays / MRI / CT / Other: When and Where?

____

Please List any Medications/Allergies

Medications	Allergies

Circle any areas that you are experiencing pain:



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HIPAA Notice:

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature: (parent if minor) ___________________________________ Date: __________

Informed Consent for Chiropractic &/or Massage Therapy Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy on me (or of said minor) by Fry Chiropractic and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Also by signing, I agree to the massage therapy cancellation policy below.

Patient's Signature: (parent if minor) _________________________________ Date: ____________

Massage Therapy Cancellation Policy

Please give 24 hours notice of a massage cancellation. If you do not give proper notice, and you do not show up for your next appointment, you may be charged a fee of $45 for the missed appointment which must be paid before your next massage. This fee cannot be submitted to your insurance company.