

# Frank Chiropractic Center

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## To the New Patient

*Most new patients come to us for skeletal system related complaints i.e. back or neck pain including herniated/bulging discs, headaches, pinched nerve syndromes, upper/lower extremity strains/sprains syndrome. We “naturally” help our patients experience relief AND in most cases successfully repair the underlying cause(s). We are also concerned about our patient’s over-all health of which exercise, nutrition and the use of natural substances play a vital role. We offer coaching in lifestyle modification and the use of natural products to assist in achieving (experiencing) optimal health.*

### **Step One (Personal History Form)**

All new patients are required to have a *Personal History Form* completely filled out (3 pages).

### **Step Two (Consultation & Examination)**

Once your file is prepared, you will have a one-on-one consultation immediately followed by a detailed examination with Dr. Frank to determine the precise cause of your health concern(s). If new x-rays are warranted, they will be taken in our office. These procedures will take approximately 60-90 minutes. *You can be assured that we will only accept you as a patient if Dr. Frank can identify the cause of your health concerns and is confident we can help.*

### **Step Three (Treatment)**

Treatment is based on the nature of your problem. We provide an assortment of treatment techniques that are all designed to accelerate your response to our care. *Will we treat you on your initial visit?* If you are in extreme discomfort and Dr. Frank is confident we can help, then care will be provided; otherwise care will begin on your follow-up *Report of Findings* visit.

### **Step Four (Report of findings)**

Your *Report of Findings* visit will include specific treatment options based on a thorough review of what was discussed in your consultation and found in the examination including any x-ray or MRI studies. Dr. Frank will address the following questions:

1. *Do you know what is wrong?*
2. *Can you help me?*
3. *What is the time frame?*
4. *What are my costs?*
5. *What can I do to help you help myself?*

### **Step Five (Functional Health Evaluation)**

On a follow-up visit you will have the option of having a *Functional Health Evaluation*. This is a comprehensive review of the quality of the function of your major organ systems coupled with a review of your personal health goals. We then create a strategy of “natural” approaches to assist you being the best you can be.

1321 South Andrews Avenue, Ft. Lauderdale, FL 33316

# Personal History

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 City: \_\_\_\_\_ Fax: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Soc Sec #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Type of work: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of spouse (if any): \_\_\_\_\_ Number of Children: \_\_\_\_\_  
 Who referred you to our office: \_\_\_\_\_

## Current Health Condition

Main Concern(s): \_\_\_\_\_

Name(s) of other Health Professionals seen, include dates of service, treatments and any special studies such as x-ray, MRI, C-T scan and results: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Others in your family with this same or similar condition: \_\_\_\_\_

Current condition is  job or work related  auto accident  injury or fall  Other: \_\_\_\_\_

If job related, have you reported this to your employer?  No  Yes Date of incident: \_\_\_\_\_

Are you being treated for any other condition?  No  Yes If yes, Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medications you now take: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Supplements you take regularly: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

## Past Health History

Surgeries/operations (include cosmetic procedures) include when and what was done (if more space is needed write on a separate sheet): \_\_\_\_\_  
\_\_\_\_\_

Major accidents and/or Injuries including any broken bones, explain injuries, when and what was treatment provided (if more space is needed write on a separate sheet): \_\_\_\_\_  
\_\_\_\_\_

Previous Chiropractic Care:  None  Doctor's name and date of last visit: \_\_\_\_\_  
\_\_\_\_\_

### Please check if you have had any of the following diseases:

- |  |                                      |                                    |   |  |
|--|--------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Chron's disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox   | <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Colitis         |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Ulcer           |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Measles     | <input type="checkbox"/> Anemia    | <input type="checkbox"/> Heart Stent              | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Thyroid   | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tumor           |

### Please check if you have had any of the following within the past 6 months:

#### Musculoskeletal

- Low Back Pain / Stiffness
- Pain/Tingling or Numbness into  
Buttock Leg or Foot  Left  Right
- Hip Pain / Stiffness  Left  Right
- Knee Pain / Stiffness  
 Left  Right
- Foot or Ankle Pain / Stiffness  
 Left  Right
- Mid-Back Pain (Between Shoulders)
- Neck Pain
- Pain/Tingling or Numbness into Arm  
Forearm or Wrist  Left  Right
- Shoulder Pain  Left  Right
- Elbow Pain  Left  Right
- Wrist Pain  Left  Right
- Hand Pain  Left  Right
- Joint Pain / Stiffness
- Difficult Chewing/Clicking Jaw
- Walking Problems
- General Stiffness
- Headaches

#### Genito-Urinary

- Bladder Trouble
- Prostate Problem
- Excessive or Frequent Urination

#### Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness or Vertigo
- Forgetfulness
- Confusion / Depression
- Fainting
- Excessive Stress
- Seizures

#### Gastro-Intestinal

- Nausea or Vomiting
- Poor / Excessive Appetite
- Diarrhea
- Constipation
- Gas/Bloating After Meals
- Heartburn
- Gall Bladder Problems
- Irritable Bowel Syndrome (IBS)
- Leaky Gut Syndrome
- Hemorrhoids
- Abdominal Cramp
- Colitis
- Black / Bloody Stool
- Weight Trouble

#### C-V-R

- Chest Pain
- Blood Pressure Problems
- Irregular Heartbeat
- Shortness of breath
- Heart Problems
- Ankle Swelling

#### Eye Ear Nose & Throat

- Vision Problems
- Sore Throat
- Dental Problems
- Hearing Difficulty
- Ear Aches
- Stuffed Nose

#### General

- Fatigue
- Allergies
- Loss of Sleep
- Migraine Headaches
- Tension Headaches
- Unusual weight loss
- Unusual weight gain

#### Female Only

- Are you pregnant?  Yes  No  
 Possibly
- When was your last period? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

# Visual and Pain Analog Scale

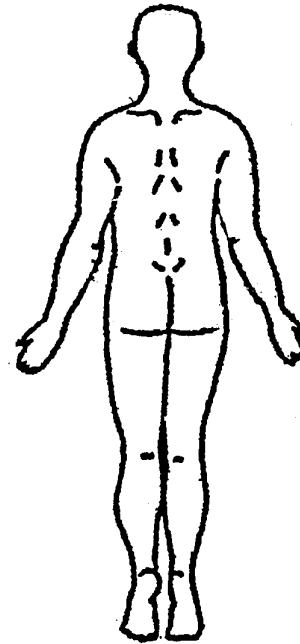
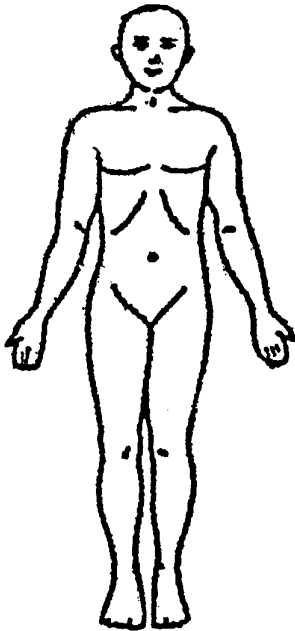
## Complete sections A & B

**A.** Please circle the location of all your symptoms on the images below AND use the letters shown to represent the description of all your complaints (many people have multiple complaints at the same and/or multiple locations).

D = Dull/ache pain or discomfort  
S = Sharp or stabbing pain

P = Pins and needles or tingling sensation  
B = Burning pain or sensation

N = Numbness  
W = Weakness



**B.** List each of your complaints in the order of their significance and rate the degree of discomfort you are experiencing on a 0-10 scale with 10 being the worst. At times the severity of complaint may vary. For example you may have a neck pain that is a constant “3” and up to a “7” with head movement. If that is the case, then write that out in the comments section.

1. Location of complaint: \_\_\_\_\_ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

2. Location of complaint: \_\_\_\_\_ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

3. Location of complaint: \_\_\_\_\_ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

4. Location of complaint: \_\_\_\_\_ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_