



# FRAIN

FAMILY CHIROPRACTIC  
WELLNESS CENTER

858 Hansen Road, Green Bay, WI 54304  
(920) 499-1333 / Fax: (920) 499-2444

## Confidential Patient Health Record

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

How did you hear about us?  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Dr. \_\_\_\_\_  Yellow pages  Drove by  Insurance Plan  Other: \_\_\_\_\_

### Personal Information

Title:  Mr.  Ms.  Mrs.  Dr.  Rev.  Miss  Prof.  other: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Suffix:  Jr  Sr  II  III  other: \_\_\_\_\_

Birth Date: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_ Sex: Male / Female Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Children (Names and Ages): \_\_\_\_\_

### Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_

Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Employment Information

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

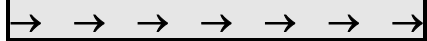
**Current Health Condition**

Please check this box if you are here for a spinal check-up, and do not have a current health condition.

Unwanted Condition (Why you are here today?): \_\_\_\_\_

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**



Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

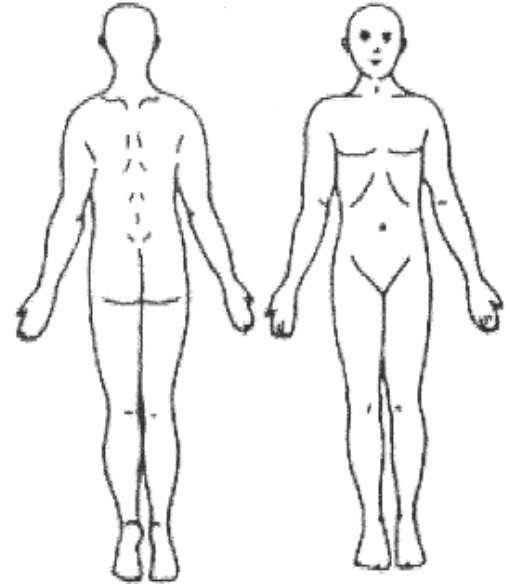
Is the Condition:  Auto Related  Job Related  Home Injury

Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ am /pm

Condition/Pain STARTED on what Date: \_\_\_\_\_



**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

**Constitutional:**  I DENY having or have had any of the symptoms or problems listed below.

- chills
- fatigue
- night sweats
- weight loss
- daytime drowsiness
- fever
- weight gain

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness
- change in vision
- field cuts
- photophobia
- blurred vision
- double vision
- glaucoma
- tearing
- cataracts
- eye pain
- itching
- wear glasses/contacts

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding
- ear drainage
- hearing loss
- nosebleeds
- sore throat
- dentures
- ear pain
- history of head injury
- postnasal drip
- tinnitus (ringing in ears)
- difficulty swallowing
- fainting
- hoarseness
- rhinorrhea (runny nose)
- TMJ problems
- discharge
- frequent sore throats
- loss of sense of smell
- sinus infections
- dizziness
- headaches
- nasal congestion
- snoring

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- asthma
- coughing up blood
- sputum production
- cough
- shortness of breath
- wheezing

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort)     high blood pressure     shortness of breath with exertion or exercise
- chest pain     low blood pressure     swelling of legs
- claudication (leg pain/ache)     orthopnea (difficulty breathing lying down)     ulcers
- heart murmur     palpitations     varicose veins
- heart problems     paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- abdominal pain     diarrhea     indigestion     abnormal stool caliber     vomiting blood
- belching     difficulty swallowing     jaundice     abnormal stool color
- black - tarry stools     heartburn     nausea     abnormal stool consistency
- constipation     hemorrhoids     rectal bleeding     vomiting

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control     cramps     irregular menstruation     vaginal bleeding
- breast lumps/pain     frequent urination     pregnancy     vaginal discharge
- burning urination     hormone therapy     urine retention     painful intercourse

**Male:**  I DENY having any of the symptoms or problems listed below.

- burning urination     frequent urination     prostate problems     painful intercourse
- erectile dysfunction     hesitancy/ dribbling     urine retention

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- cold intolerance     excessive hunger     goiter     unusual hair growth
- diabetes     excessive thirst     hair loss     voice changes
- excessive appetite     abnormal frequency of urination     heat intolerance

**Skin:**  I DENY having any of the symptoms or problems listed below.

- changes in nail texture     hair loss     itching     skin lesions / ulcers
- changes in skin color     hives     paresthesias     varicosities
- hair growth     history of skin disorders     rash

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- dizziness     limb weakness     numbness     slurred speech     tremor
- facial weakness     loss of consciousness     seizures     stress     unsteadiness of gait/ loss of balance
- headache     loss of memory     sleep disturbance     strokes

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- anhedonia     behavioral change     convulsions     memory loss
- anxiety     bi-polar disorder     depression     mood change
- loss or change in appetite     confusion     insomnia

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- anaphalaxis     itching     chronic nasal congestion     sneezing
- food intolerance     acute nasal congestion     rash

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- anemia     blood clotting     bruising easily     lymph node swelling
- bleeding     blood transfusion     fatigue

**PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

**Previous Care for this Same Condition:**

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Were you satisfied with the results of your treatment?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Were you satisfied with your care?  Yes  No. Why? \_\_\_\_\_

Do you wear any of the following?  Heel Lifts  Innersoles  Arch Supports  Orthotics  Other \_\_\_\_\_

For how long? \_\_\_\_\_ Were they prescribed by a doctor?  Yes or  No.

**Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

**Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.**

	Dosage	For What Condition, if any?	How long have you been taking this?

**Childhood Illness (es): Check all conditions you had as a child. CIRCLE all CURRENT conditions.**

- |                                                     |                                                      |                                    |                                             |
|-----------------------------------------------------|------------------------------------------------------|------------------------------------|---------------------------------------------|
| <input type="checkbox"/> ADD                        | <input type="checkbox"/> chicken pox                 | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis          |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis             | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder   |
| <input type="checkbox"/> allergies/hayfever         | <input type="checkbox"/> depression                  | <input type="checkbox"/> HIV       | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia                     | <input type="checkbox"/> diabetes                    | <input type="checkbox"/> measles   | <input type="checkbox"/> spina bifida       |
| <input type="checkbox"/> asthma                     | <input type="checkbox"/> ear infections              | <input type="checkbox"/> mumps     | <input type="checkbox"/> other:             |
| <input type="checkbox"/> bedwetting                 | <input type="checkbox"/> fetal drug exposure         | <input type="checkbox"/> psoriasis |                                             |
| <input type="checkbox"/> cerebral palsy             | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash      |                                             |

**Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.**

- |                                     |                                                 |                                               |                                               |
|-------------------------------------|-------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> ADD        | <input type="checkbox"/> cystic kidney disease  | <input type="checkbox"/> hypertension         | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression             | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis            |
| <input type="checkbox"/> anemia     | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease        | <input type="checkbox"/> seizures             |

- |                                          |                                                 |                                                       |                                                           |
|------------------------------------------|-------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> arthritis       | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease                 | <input type="checkbox"/> shingles                         |
| <input type="checkbox"/> asthma          | <input type="checkbox"/> eczema                 | <input type="checkbox"/> lupus erythema (discoïd)     | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer          | <input type="checkbox"/> emphysema              | <input type="checkbox"/> lupus erythema (systemic)    | <input type="checkbox"/> STD's (unspecified)              |
| <input type="checkbox"/> cerebral palsy  | <input type="checkbox"/> eye problems           | <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> suicide attempt(s)               |
| <input type="checkbox"/> chicken pox     | <input type="checkbox"/> fibromyalgia           | <input type="checkbox"/> parkinson's disease          | <input type="checkbox"/> thyroid problems                 |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease          | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo                          |
| <input type="checkbox"/> CRPS (RSD)      | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> pneumonia                    | <input type="checkbox"/> other:                           |
| <input type="checkbox"/> CVA (stroke)    | <input type="checkbox"/> HIV                    | <input type="checkbox"/> psoriasis                    |                                                           |

**Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- |                                                  |                                           |                                               |                                              |
|--------------------------------------------------|-------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> angioplasty             | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy            | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section       | <input type="checkbox"/> dental sugery    | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsilectomy        |
| <input type="checkbox"/> carpal tunnel repair    | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other: _____        |
| <input type="checkbox"/> coronary artery bypass  | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           | _____                                        |

**Females ONLY: Ob/Gyn Mark all that apply below.**

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

**Menstrual History.**

I... <input type="checkbox"/> currently have menses.	<input type="checkbox"/> currently DO NOT have menses.
My menses... <input type="checkbox"/> are regular.	<input type="checkbox"/> are NOT regular.
_____ Age of first menses	_____ Age when metaphase began
Date of last menses: _____ / _____ / _____	

**Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- |                                           |                                                                 |                                                        |
|-------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> back injury      | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident        |
| <input type="checkbox"/> broken bones     | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild)     |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident                    | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe)    | <input type="checkbox"/> joint injury                           | <input type="checkbox"/> soft tissue injury (severe)   |
| <input type="checkbox"/> fracture         | <input type="checkbox"/> laceration (severe)                    | <input type="checkbox"/> other:                        |

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                      |                                |                                   |                                                 |                                         |
|----------------------|--------------------------------|-----------------------------------|-------------------------------------------------|-----------------------------------------|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**Social History: Mark all that apply below.**

- Alcohol:  do not drink alcohol  social consumption only  drink the following regularly (mark below)
- beer  liquor  wine; quantity of \_\_\_\_\_ oz./glasses per  day  week  month

My Dietary Intake consists mainly of the following: (mark all that apply)

- high fat             high salt             low fiber
- high fiber         low calorie         low salt
- high protein     low carbohydrate  low sugar

What is the highest level of Education you have completed: \_\_\_\_\_

Substance:  never used illegal drugs             has not used illegal drugs since \_\_\_\_\_ .  
 never used IV drugs                                     used illegal drugs for \_\_\_\_\_ (how long?)

Tobacco:  Do not use tobacco    Do not smoke cigars, cigarettes or pipe    Live with a smoker    Quit smoking  
 Smoke: # \_\_\_\_ per  Day    Week    Month;  Chew: # \_\_\_\_\_ cans per  Day    Week    Year

**Insurance Information:**

Who Is Responsible For Your Bill?    **YOU and...** (mark appropriate box(es))     Myself ONLY

Spouse    Worker's Comp    Auto Insurance    Medicare    Other (be specific): \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_    Health ID Card #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_    Group #: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Primary Care Physician: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?    Yes    No    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_    Time: \_\_\_\_\_ am/pm

Carrier: \_\_\_\_\_    Policy # \_\_\_\_\_

Carriers Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    Adjuster: \_\_\_\_\_

Claim #: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Frain Family Chiropractic Wellness Center, Ltd. 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 Frain Family Chiropractic Wellness Center, Ltd., will be credited to my account upon 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. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_