Frackson Health Care

fracksonhealthcare.com
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Dr. Taylor Trotter, D.C.

CONFIDENTIAL PATIENT HISTORY

Name _____ CareCard # _____

Birth date *(mm/dd/yyyy)* _____

Address _____ City _____

Postal Code _____Home phone _____Work _____

Cell _____

Occupation _____Employer _____

Emergency contact/Relationship _____/ _____

Phone _____

Have you ever been to a chiropractor before? ____ What was the problem? _____

How did you choose our office? _____

What is your primary complaint/concern?_____

When & How did this begin? _____

Did it occur ☐ Suddenly ☐ Gradually Have you had this or similar conditions in the past? ☐ Yes ☐ No

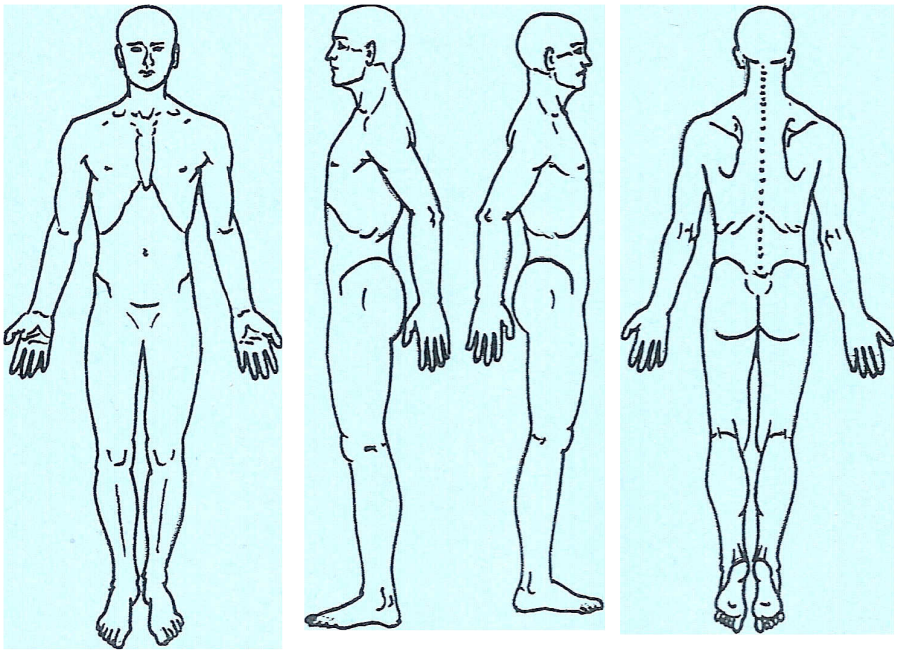
If yes, please explain _____

What aggravates your condition? _____

What makes it better? _____

Please mark off the areas of your complaint on the diagram below. Please use the following symbols on the diagram to accurately describe your problem:

PPP Where you experience PAIN
CCC Where you experience CRAMPING
NNN Where you experience NUMBNESS
WWW Where you experience WEAKNESS
HHH Where you experience BURNING/HEAT
TTT Where you experience TINGLING



(Over please)

If pain, which of these words best describes it:

☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Shooting

☐ Other: _____

Please circle the number describing the intensity of your symptoms:

No discomfort → 0 1 2 3 4 5 6 7 8 9 10 ← *Unbearable discomfort*

What percentage of awake hours do you experience these symptoms? _____%

Is the condition getting progressively worse? ☐Yes ☐No Is your condition: ☐ Constant ☐ Intermittent

Is this condition interfering with your: ☐ Work ☐Sleep ☐ Daily routine ☐ Other _____

Have you had previous treatment for the above symptoms? ☐Yes ☐No If yes, please specify:

Where? When? What kind of treatment? _____

How did you respond? (eg. "helped," "got worse," etc.) _____

Has there been any medical diagnosis of your complaint? ☐ Yes ☐ No If yes, list Doctor's name and the diagnosis _____

Please list any surgeries and year: _____

Please list any Prescription drugs, Over the Counter drugs, Vitamins, and Natural Supplements you now take:

_____

_____

Do you currently wear orthotics? ☐ Yes ☐ No

Are you affected by any of the following? Please place a checkmark in the box:

O = occasionally F = frequently C= Constant

	O	F	C		O	F	C		O	F	C
Asthma				Headaches				Dizziness			
Backache				Migraines				High Blood Pressure			
Neck pain				Heartburn				FEMALES:			
Allergy				Digestive upset				Painful menstruation			
Earache				Constipation				PMS			
Sore throat				Sinus trouble				Are you pregnant?	Yes ☐		No ☐

What do you hope to gain from your treatment here? Check all that apply:

☐ Pain reduction ☐Return of function ☐ Guidance in future Prevention ☐ Other:

Please keep in mind that your treatment time is reserved specifically for you. A minimum of 24 hours notice for rescheduling or canceling appointments is required. There will be a charge of $25 for missed appointments or cancellations without 24 hours notice.

Please initial here to indicate you have read & understood this policy. ☐

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____Date: _____ _