

# Frackson Health Care

fracksonhealthcare.com  
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## DR. E. Ted Frackson 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 \_\_\_\_\_

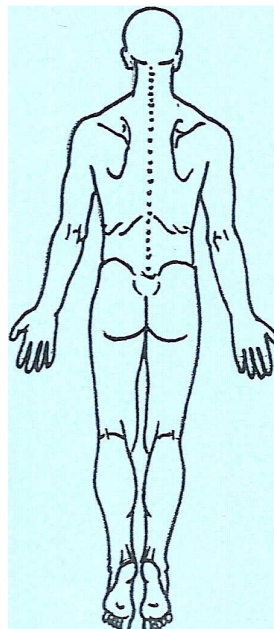
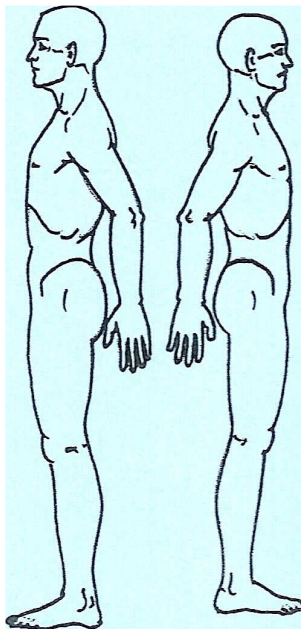
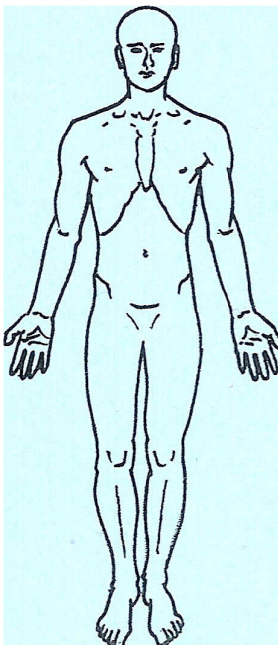
What aggravates your condition? \_\_\_\_\_

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				<b>FEMALES:</b>				
Allergy				Digestive upset				Painful menstruation				
Earache				Constipation				PMS				
Sore throat				Sinus trouble				Are you pregnant?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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: \_\_\_\_\_