Drs. Frisbee and Kracht Family Chiropractic

119 Truxton Ave. - Ft. Walton Beach, Florida 32547 Office: (850) 862-4313 Fax (850) 863-1765

CHIROPRACTIC PATIENT HISTORY

Date of Birth_____Age: _____Social Security Number: _____Today's Date: _____
Last Name: _____ First Name: _____ Nickname_____
Address: _____Apt # _____
City: _____STATE: _____ Zip: _____
Phone: (H) _____(Cell) _____(Cell Carrier)_____
Email: _____
☐ Married ☐ Single ☐ Divorced ☐ Widowed
Emergency Contact: _____ (Cell) _____
Your Occupation: _____ Employer: _____
Have you ever been to another doctor for this problem? Y / N If so, who? _____
Name of Primary Physician?_____Who referred you to our office?_____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT:_____

- Date when symptom first appeared and cause:_____
- Did it begin: Unknown_____ Gradual: _____Sudden: _____Progressive over time: _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn_____ Throb _____
- Does the Pain Radiate into your Arm _____Leg _____ Other_____ Does not radiate _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): _____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

•What Makes the problem worse? Sitting __ Standing __ Bending __Coughing __ Lying down ___ Walking __ Sneezing ___ Other _____

- Have you ever had this problem before? Y / N • When?_____
- Is the problem getting worse? Y / N • Does it bother you at night? Y / N • Any unexplained weight loss? Y / N

OTHER COMPLAINT:_____

- Date when symptom first appeared and cause:_____
- Did it begin: Unknown_____ Gradual: _____Sudden: _____Progressive over time: _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn_____ Throb _____
- Does the Pain Radiate into your _____Arm _____Leg _____Does not radiate _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): _____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

•What Makes this problem worse? Sitting __ Standing __ Bending __Coughing __ Lying down ___ Walking __ Sneezing ___ Other _____

- Have you ever had this problem before? • When?

PLEASE CIRCLE ALL OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweating
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or Pain in
Arms, Hands, Legs
Allergy
Wheezing
Neuralgia

GASTROINTESTINAL SYMPT.
Poor Appetite
Difficult Digestion
Excessive Hunger
Belching of Gas
Nausea
Vomiting
Vomiting of Blood
Pain Over Stomach
Distention of Abdomen
Constipation
Diarrhea
Colon Trouble
Hemorrhoids (Piles)
Intestinal Worms
Liver Trouble
Gall Bladder Trouble
Jaundice
Colitis

E.E.N.T.
Failing Vision
Nearsightedness
Farsightedness
Crossed Eyes
Eye Pains
Deafness
Earache
Noises
Ear Discharge
Nose Bleeds
Nasal Obstruction
Sore Throat
Hoarseness
Hay Fever
Asthma
Dental Decay
Gum Trouble
Frequent Colds
Enlarged Thyroid
Nasal Drainage
Tonsillitis
Sinus Infection
Enlarged Glands

Desired Weight: (Significantly Below, Below, Good, Over, Significantly Over)
Struggled Weight Patterns: (Most of life, last 10 years, Last 5 years, Within last year)
Moderate to significant Mental Health or Relational Stresses (Yes or No)

CARDIO-VASCULAR
Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Previous Heart Attack
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Previous Stroke

MUSCLE & JOINT SYMP.
Neck Pain
Low Back Pain
Swollen Joints
Tremors
Foot Trouble
Painful Tail Bone
Hernia
Spinal Curvature
Faulty Posture

RESPIRATORY
Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficult Breathing

GENITOURINARY SYMPT.
Frequent Urination
Painful Urination
Bloody Urine
Pus in Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

SKIN
Skin EruptionsPainful
Itching
Bruising
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

FOR WOMEN
Painful Menstrual Periods
Vaginal Discharge
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Previous Miscarriage
Congested Breast
Lumps in Breast
Menopausal Symptoms
ANY CHANCE OF YOU
BEING PREGNANT?
YES_____ NO_____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Please list all past surgeries, date of most recent diagnostic imaging, and blood work:

Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____

Please list all previous accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications, vitamins, supplements you are currently taking. Include the amount, brand names, and how long you have been taking them:

Please list any allergies:

PATIENT HISTORY

NURITION:

A. How many meals/snacks do you eat a day? _____

B. Do you feel tired, sleepy, drowsy within 15-30 mins. after eating a large meal? Yes or No

C. Three-Four hours after a meal do you feel tired, have a brain fog, or sluggish? Yes or No

D. What do you drink throughout the day? _____

_____

E. How much water do you drink daily? _____

F. How much caffeine do you drink daily? _____

G. How much alcohol do you drink in 1 week? _____

H. Do you use tobacoo products? If so, how often? _____

I. How many sugary drinks, including fruit juice do you drink daily? _____

J. Do you eat vegetables and fruit daily? _____

EXERCISE:

A. How often do you exercise? _____

B. How long have you been exercising? _____

C. Do you have a stretch routine? Describe. _____

_____

D. What type of exercise do you do? _____

_____

_____

_____

E. What is the duration for each type of exercise you do? _____

_____

_____

_____

Do you have a stress management strategy? (ie, meditation, walking, hobby) If yes, what is it?

_____

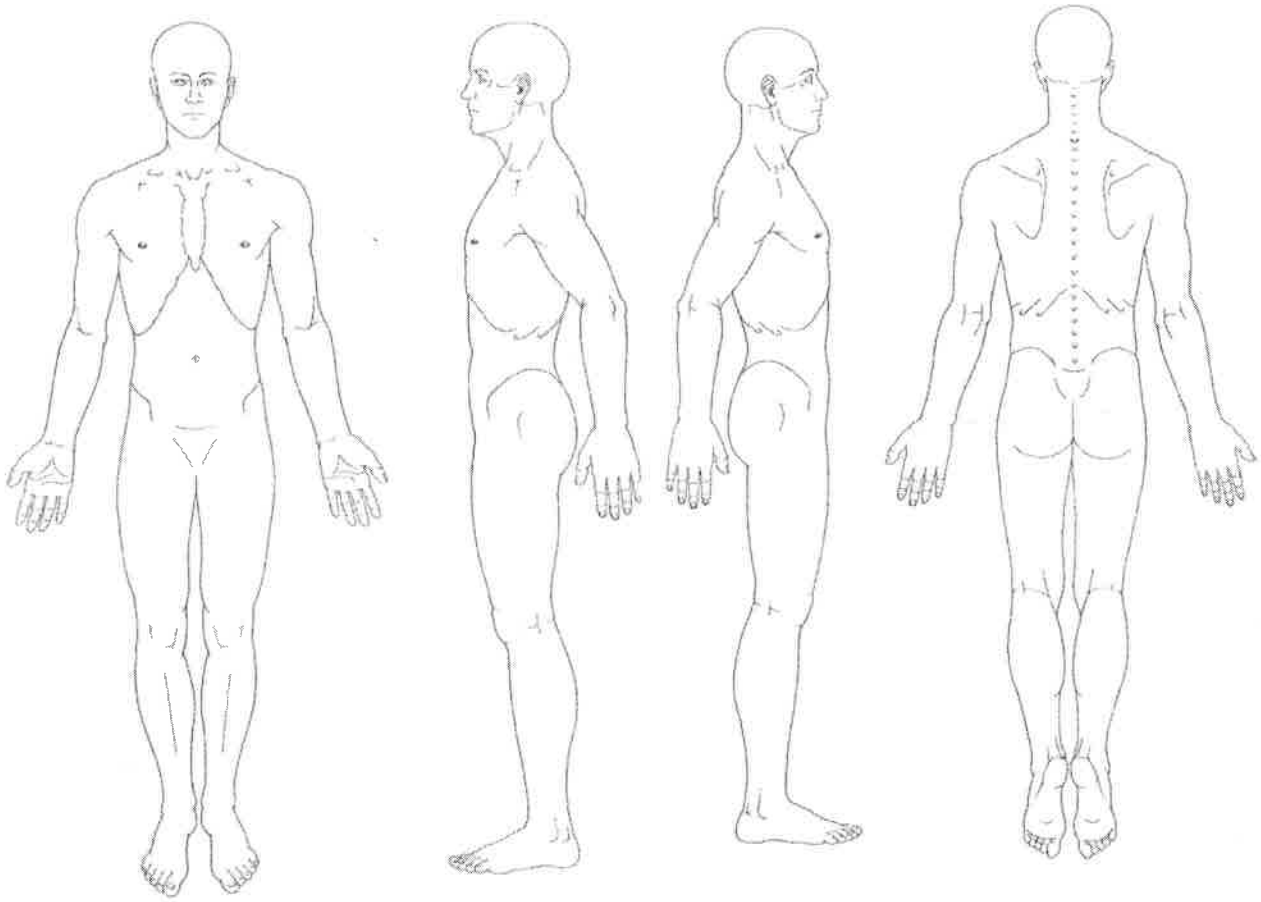
Do you socialize with other people and how often? _____

How much fun do you have an a scale from 1-10? (1 being none and 10 being all day, everyday)

_____

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

P	**Where you experience Pain**
N	**Where you experience Numbness**
T	**Where you experience Tingling**
B	**Where you experience Burning**
C	**Where you experience Cramping**

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OFFICE POLICIES

Patient-Doctor Agreements
The purpose of these agreements is to allow us to more completely serve you and to get the best result in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

Signing In
When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order of appointment times. Other patients may be called before you because their doctor or therapist may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

New Injuries
In the event you sustain a new injury from an accident please let the front desk know as soon as possible. There may be additional paper work to be filed out.

Appointments
After your treatment, please be sure to stop at the front desk to take care of any co-payments, co-insurances, or balances, and be sure to make your next appointment.

Payment of Bills
We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our clinic coordinator immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home and you have not paid our office, it should be brought or sent to our office as soon as possible unless told specifically this is not the case. Please also bring in the attached explanation of benefits (EOB).

Rescheduling Appointments
Your doctor will set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day if possible. If the same day is not possible, be sure to make up the missed appointment within one week. **A 24-hour advance notice phone call is required, so that we may fill that slot. If 24 hours notice is not given a cancellation fee will be charged to your account.**

Progress Evaluations and Re-Examinations
Progress evaluations and re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments. There will be a $10.00 fee for re-examinations.

Upsets
We are here to serve YOU. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion etc.). We see your comments as helping us to help you and others.

Patient Signature_____ Date: _____

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Informed Disclosure and Consent:
Chiropractic Spinal Adjustment Procedures and Physical Modalities

You have the right as a patient to be informed about your injuries and/or condition, as well as the doctor's recommended procedures and any necessary referrals to be utilized to evaluate and treat your complaints. There are potential risks and benefits in all forms of commonly used treatment, including deciding on non-treatment in the hope that the pain and/or lack of ability to perform normal activities will eventually go away. Evaluations at this office consist of a thorough regional examination of your complaints and any necessary diagnostic X-rays. If you are a female of child bearing age, you must inform the physician if there is even the slightest possibility that you may be pregnant (you must be sexually active and have missed a menstrual period), as X-rays can have harmful effects on a fetus. The physician will perform various Range of Motion and Orthopedic Stress Tests to determine the most likely cause of your pain and most appropriate course of treatment for each of your complaints. Your non-surgical spinal-related complaints will be treated with specific chiropractic spinal adjustment procedures using the hands or a mechanical instrument. You may feel joint movement and hear joint noises during the procedure. Minor temporary soreness may occur, particularly early in the treatment, or during periods of flare-up with your return to normal activities; this is also true of massage therapy and physical therapy. More significant risks (for example, fractures, sprains/strains, strokes and disc injuries) are rare. Chiropractors, or D.C.'s, have the lowest medical malpractice insurance claims of all primary care physicians in the USA, including M.D., D.O., D.D.S., D.V.M. and D.P.M. practitioners. The for-profit malpractice insurance industry has determined there is less risk involved in chiropractic spinal adjustment procedures and the adjunct therapies than in the prescribing of medication and surgery (both of which, however, may be necessary for a patient's recovery). I do not expect the doctor to be able to anticipate and explain all potential risks and complications, and I wish to rely on the doctor's education, training and experience to exercise judgment during the course of treatment, based on the facts then known, to do what is in my best interest. I further acknowledge that treatment may worsen or fail to relieve all of my spinal-related pain and that no guarantee of a "new spine" or complete cure have been given. I have had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the prescribed treatment plan and intend for this consent form to cover the entire course of treatment for my current complaints and for future conditions for which I seek treatment for my current complaints and/or therapists working at this office (or for the minor patient named below for whom I am the custodial parent or legal guardian).

Signature: _____ Date: _____

Printed Name: _____

If a minor (less than 18 years old), Parent or Guardian's name: _____

Parent or Guardian's signature: _____

Release Of Records / Payment Agreement
And Assignment Of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____ Date of Birth: _____ Date: _____

I hereby authorize: Drs. Frisbee and Kracht, my Health Care Provider/Facility, **to release any and all medical information** to my insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records are without the expressed written consent of the patient or the patient's legal representatives.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges. I also understand that as a self-pay patient that is not filing any insurance, for any reason, I am responsible for my balance in full at the above mentioned facility.

Assignment of Benefits: I hereby assign to Drs. Frisbee and Kracht, my health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____ Date: _____

Witness: _____ Date: _____

Drs. Frisbee and Kracht Family Chiropractic

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for seven years.

_____ Date: _____
Patient Name (Please Print)

_____
Parent, Guardian, or Patient's legal representative

_____
Signature

Please initial next to your answer. You give permission to our office to release Privacy Health Information to...

Spouse _____yes _____no name(s)_____

Parents _____yes _____no name(s)_____

Children_____yes _____no name(s)_____

Guardian_____yes _____no name(s)_____

Other _____yes _____no name(s)_____