WELCOME TO FRAY CHIROPRACTIC OFFICE

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________

TODAY'S DATE: ____________

PATIENT INFO: PLEASE PRINT EMAIL ADDRESS: ____________________

PATIENT'S NAME: ____________________

SEX: M/ F DATE OF BIRTH ____________ AGE ________

HOME ADDRESS: ____________________

CITY ____________________ STATE ________ ZIP ________

EMPLOYER ____________________ OCCUPATION ____________

FULL OR PART TIME: ________

HOME PH#: ________ WORK PH#: ____________ CELL PH#: ________
MAY WE CONTACT YOU AT WORK? _____YES _____NO

MARITAL STATUS: ________

SPOUSES NAME: ____________________ DATE OF BIRTH ____________

EMPLOYER____________________

DO YOU HAVE HEALTH INSURANCE YOU WISH US TO FILE? _______YES _______NO

WHO IS THE PRIMARY INSURED? _______SELF _______SPOUSE ______ OTHER

IF OTHER, PLEASE EXPLAIN: ____________________

FEMALES: ARE YOU PREGNANT? _______YES _______NO IF YES, DUE DATE? ____________

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

PATIENT OR AUTHORIZED PERSONS SIGNATURE FOR EXAMINATION AND TREATMENT

____

PLEASE SIGN

1. **The symptom(s) that have prompted me to seek care today include:** ____________________

____

Patient name ____________________

2. **And are the result of (darken circle):** ◯ An accident or injury
   ◯ Work ◯ Auto ◯ Other ____________________
   ◯ A worsening long-term problem
   ◯ An interest in: ◯ Wellness ◯ Other ____________________

3. **Onset** (When did you first notice your current symptoms?) ____________________

4. **Intensity** (How extreme are your current symptoms?)
0◯-◯-◯-◯-◯-◯-◯-◯-◯-◯-◯10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? ____________________

6. **Quality of symptoms** (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other ____________________

7. **Location** (Where does it hurt?) Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past

8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ____________________
What tends to lessen the problem? ____________________

10. **Prior interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other ____________________
◯ Physical therapy ◯ Massage ____________________

11. **What else should the doctor know about your current condition?** ____________________

____

12. **How does your current condition interfere with your:**

Work or career: ____________________

Recreational activities: ____________________

Household responsibilities: ____________________

Personal relationships: ____________________

Consultation Notes

13. **Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	NONE ◯
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	NONE ◯ Initials ____

Doctor's Initials ____________________

FRAY CHIROPRACTIC

DAVID E. FRAY, D.C.
6632 A. RAYTOWN RD.
RAYTOWN, MO. 64133

Ph. #816/356-9313
Fax. #816/356-8625

INSURANCE AUTHORIZATION

SIGNATURE ON FILE

Please read and *initial* each box:

_____ I authorize use of this form on all of my insurance transmissions

_____ I authorize release of information to all of my insurance carriers

_____ I understand that I am responsible for my bill

_____ I authorize my doctor to help obtain payment from my insurance carrier

_____ I authorize payment direct to my doctor

_____ I permit a copy of this authorization to be used in place of the original

____
Please Print Patients Name

______________________________ ______________________
Signature **Date Signed**

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	NONE ○ Initials ____

Patient name ____________________

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____________
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____________
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____________
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____________

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently.**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____________

○	○	Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

FAMILY

18. Family History

Some health issues are hereditary. Tell the doctor about the health of your immediate family members.

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

19. Are there any other hereditary health issues that you know about? ____________________

SOCIAL

20. Social History

Tell the doctor about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? ____________
Coffee use	○ Daily	○ Weekly	How much? ____________
Tobacco use	○ Daily	○ Weekly	How much? ____________
Exercising	○ Daily	○ Weekly	How much? ____________
Pain relievers	○ Daily	○ Weekly	How much? ____________
Soft drinks	○ Daily	○ Weekly	How much? ____________
Water intake	○ Daily	○ Weekly	How much? ____________
Hobbies:			

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? ____________

23. How much sleep do you average per night? ____ **Hours**

24. What is the type and approximate age of your mattress and pillow? ________

25. What is your preferred sleeping position? ________

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ____________

28. In addition to the main reason for your visit today, what additional health goals do you have? ____________

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: ____________

Signature ____________

Date (MM/DD/YYYY) ____________

Patient name ____________

Consultation Notes

Doctor's Initials ____________

Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Fray Chiropractic Clinic

Effective: April 14, 2003
Updated: September 23, 2013

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Fray Chiropractic Clinic. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Donna Fray

Fray Chiropractic Clinic also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached. Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials.
__________ (please initial if approve)

If you have any questions regarding this notice or our health information privacy policies, please contact: Donna Fray at: Fray Chiropractic Clinic,
10803 B E 350 Highway, Raytown, Missouri, 816-356-9313
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: ____________________________________ (you may receive PHI through email)

Print Patient Name: ____________________________________

Signature Patient/Personal Representative: ____________________________________

Relationship of Personal Representative: ____________________________________

Date of Signature: ____________________

Staff complete only if NO signature is obtained, if it is not possible to obtain the patient's Acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

- Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- Other:____________________________

Staff Signature: date: ________________________________ date: __________________