Whole Body Wellness

Frigaard Chiropractic Corp.

Tel: (951) 683-9807
Fax: (951) 824-7555
6391 Magnolia Ave., Suite C
Riverside, CA 92506

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full Name	Date:
Address: City State Zip	
Home Phone:	Work Phone:
Cell Phone:	Email Address:
Date of Birth:	Age:
# of Children:	Pregnant? Yes ____ No ____
Height:	Weight:
Marital Status: M S W D	Spouse/Guardian Name:
Patient’s Occupation:	
Employer's Name & Address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	

Who may we thank for referring you? ____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the “General Health History.”

Are you here due to an accident OR injury? Yes No Date of Accident/Injury ____________________

Health Concerns

Please list your health concerns according to their severity	Rate of Severity 1 = Mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where? ______________________________
____
____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit? ____
____

____

I do (do not) have a family history of this or similar symptoms (Please explain): ______________________________
____
____

Which activities aggravate your condition? ____
____

Other Doctors You Have Seen For This Condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well-being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (Please describe)	☐

Doctors Details

Name	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily Routine ☐	Sports/Exercise ☐	Other ☐ (Please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this, as it will help us help you!

Have you had any surgery: (Please include all surgeries)

1. Type:	When?	Doctor:
2. Type:	When?	Doctor:
3. Type:	When?	Doctor:
4. Type:	When?	Doctor:

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

____

____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____

____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Gout	☐ Eczema	☐ Diabetes	☐ Miscarriage	☐ Constipation	☐ Thyroid Problems
☐ Polio	☐ Anemia	☐ Diarrhea	☐ Pneumonia	☐ Nervousness	☐ Venereal Disease
☐ Stroke	☐ Asthma	☐ Back Pain	☐ Headaches	☐ Heart Disease	☐ Multiple Sclerosis
☐ Allergy	☐ Pleurisy	☐ Neck Pain	☐ Convulsions	☐ Sinus Problems	☐ Whooping Cough
☐ Cancer	☐ Neuritis	☐ HIV (Aids)	☐ Depression	☐ Arteriosclerosis	☐ Ringing in the Ears
☐ Ulcers	☐ Arthritis	☐ Migraines	☐ Heart Attack	☐ Rheumatic Fever	☐ Menstrual Cramps
☐ Malaria	☐ Epilepsy	☐ Cold Sores	☐ Emphysema	☐ Low Blood Sugar	☐ High Blood Pressure
☐ Mumps	☐ Measles	☐ Alcoholism	☐ Tuberculosis	☐ Irregular Periods	☐ Gall Bladder Problems

Other (please explain): ____

____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical Stress (falls, accidents, work posture, etc.)
   a. ____
   b. ____
   c. ____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____
   b. ____
   c. ____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____
   b. ____
   c. ____

Is there anything else which may help to better understand you and your health, which has not been discussed?

____

____

Why are you here at this point in time? What is the MAIN GOAL of your visit with us today?

____

____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ **Date**: ________________

Signature: ____