

Frank Chiropractic Center

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To the New Patient

Most new patients come to us for health concerns related to their skeletal system (back or neck pain, pinched nerve syndromes, herniated discs, upper or lower extremity symptoms of pain, stiffness, etc). We get excellent results in the removal of symptoms AND in the repair of their causes. We are also concerned about our patient's over-all health. Nutrition plays a vital role; we offer coaching in diet and the use of natural products to assist in achieving optimal health.

Step One (History Form)

All new patients are required to have a *Personal History* form completely filled out (3 pages).

Step Two (Consultation & Examination)

Once your file is prepared, you will have a one-on-one consultation immediately followed by a detailed examination with Dr. Frank to determine the precise cause of your health concern(s). If new x-rays are warranted, they will be taken in our office. These procedures will take approximately 60-90 minutes. *You can be assured that we will only accept you as a patient if Dr. Frank can identify the cause of your health concerns and is confident we can help.*

Step Three (Treatment)

Will we treat you on your initial visit? If we accept you for care and if you are in extreme discomfort, then care will be provided; otherwise care will begin on your follow-up *Report of Findings* visit. Treatment is based on the nature of your problem. We treat functional changes to the spine & extremities, disc herniations/bulges and assorted muscle injuries and problems.

Step Four (Report of findings)

Your *Report of Findings* visit will include specific treatment options based on a thorough review of what was discussed and found in the examination including any x-ray or MRI studies. Dr. Frank will address the following questions:

1. "Do you know what is wrong?"
2. "Can you help me?"
3. "What is the time frame?"
4. "What are the costs?"

Step Five (Anti-Oxidant scanning device)

On a follow-up visit you will have the option of being tested with a state-of-the-art device called a BioPhotonic Scanner. This device accurately measures anti-oxidant levels within the body. Higher levels of anti-oxidants provide better protection from the damaging affects of free radicals. Levels of anti-oxidants are affected by all forms of stress, diet and supplement intake.

1321 South Andrews Avenue, Ft. Lauderdale, FL 33316

Personal History

Date: _____
 Name: _____ Home phone: _____
 Address: _____ Cell phone: _____
 City: _____ Fax: _____
 State: _____ Zip: _____ E-Mail: _____
 Birth Date: _____ Age: _____ Sex: M F Soc Sec #: _____
 Employer: _____ Type of work: _____
 Address: _____ Work phone: _____
 City: _____ State: _____ Zip: _____
 Name of spouse (if any): _____ Number of Children: _____
 Who referred you to our office: _____

Current Health Condition

Main Concern(s): _____

Name(s) of other Health Professionals seen, include dates of service, treatments and any special studies such as x-ray, MRI, C-T scan and results: _____

Others in your family with this same or similar condition: _____

Current condition is job or work related auto accident injury or fall Other: _____

If job related, have you reported this to your employer? No Yes Date of incident: _____

Are you being treated for any other condition? No Yes If yes, Explain: _____

List all medications you now take: 1. _____ 2. _____
 3. _____ 4. _____ 5. _____
 6. _____ 7. _____ 8. _____

Supplements you take regularly: 1. _____ 2. _____
 3. _____ 4. _____ 5. _____
 6. _____ 7. _____ 8. _____

Past Health History

Surgeries/operations (include cosmetic procedures) include when and what was done (if more space is needed write on a separate sheet): _____

Major accidents and/or Injuries including any broken bones, explain injuries, when and what was treatment provided (if more space is needed write on a separate sheet): _____

Previous Chiropractic Care: None Doctor's name and date of last visit: _____

Please check if you have had any of the following diseases:

- | | | | | |
|--|--------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chron's disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Measles | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tumor |

Please check if you have had any of the following within the past 6 months:

Musculoskeletal

- Low Back Pain / Stiffness
- Pain/Tingling or Numbness into
Buttock Leg or Foot Left Right
- Hip Pain / Stiffness Left Right
- Knee Pain / Stiffness
 Left Right
- Foot or Ankle Pain / Stiffness
 Left Right
- Mid-Back Pain (Between Shoulders)
- Neck Pain
- Pain/Tingling or Numbness into Arm
Forearm or Wrist Left Right
- Shoulder Pain Left Right
- Elbow Pain Left Right
- Wrist Pain Left Right
- Hand Pain Left Right
- Joint Pain / Stiffness
- Difficult Chewing/Clicking Jaw
- Walking Problems
- General Stiffness
- Headaches

Genito-Urinary

- Bladder Trouble
- Prostate Problem
- Excessive or Frequent Urination

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness or Vertigo
- Forgetfulness
- Confusion / Depression
- Fainting
- Excessive Stress
- Seizures

Gastro-Intestinal

- Nausea or Vomiting
- Poor / Excessive Appetite
- Diarrhea
- Constipation
- Gas/Bloating After Meals
- Heartburn
- Gall Bladder Problems
- Irritable Bowel Syndrome (IBS)
- Leaky Gut Syndrome
- Hemorrhoids
- Abdominal Cramp
- Colitis
- Black / Bloody Stool
- Weight Trouble

C-V-R

- Chest Pain
- Blood Pressure Problems
- Irregular Heartbeat
- Shortness of breath
- Heart Problems
- Ankle Swelling

Eye Ear Nose & Throat

- Vision Problems
- Sore Throat
- Dental Problems
- Hearing Difficulty
- Ear Aches
- Stuffed Nose

General

- Fatigue
- Allergies
- Loss of Sleep
- Migraine Headaches
- Tension Headaches
- Unusual weight loss
- Unusual weight gain

Female Only

- Are you pregnant? Yes No
 Possibly
- When was your last period? _____

Name: _____ Date: _____

Visual and Pain Analog Scale

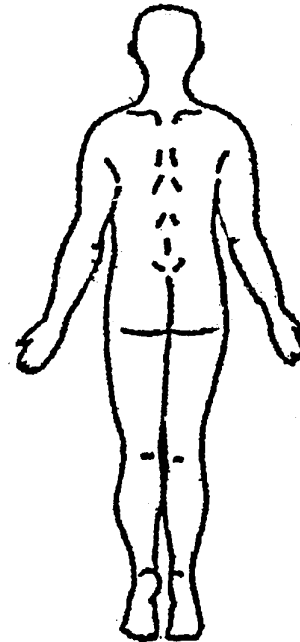
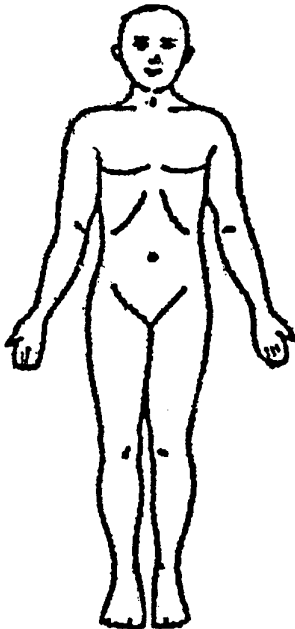
Complete sections A & B

A. Please circle the location of all your symptoms on the images below AND use the letters shown to represent the description of all your complaints (many people have multiple complaints at the same and/or multiple locations).

D = Dull/ache pain or discomfort
S = Sharp or stabbing pain

P = Pins and needles or tingling sensation
B = Burning pain or sensation

N = Numbness
W = Weakness



B. List each of your complaints in the order of their significance and rate the degree of discomfort you are experiencing on a 0-10 scale with 10 being the worst. At times the severity of complaint may vary. For example you may have a neck pain that is a constant "3" and up to a "7" with head movement. If that is the case, then write that out in the comments section.

1. Location of complaint: _____ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: _____

2. Location of complaint: _____ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: _____

3. Location of complaint: _____ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: _____

4. Location of complaint: _____ Severity: 0 1 2 3 4 5 6 7 8 9 10

Comments: _____