Patient Information Form

Dr. Ronald Fried, DC
135 S. Livernois Rd, Rochester Hills MI 48307

Name: _____ Email Address: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Employer: _____

Were you referred to our office? □ Yes □ No If yes, by whom: _____

Medical History

Have you been treated for any conditions in the last year? □ Yes □ No

If yes, please describe: _____

Date of last physical exam: _____ Is there a chance you are pregnant? □ Yes □ No

Have you had x-rays taken? □ Yes □ No If yes, where: _____

Do you have any allergies: □ Yes □ No If yes, please list: _____

_____

Have you had any surgeries? □ Yes □ No If yes, please list: _____

_____

Please list any medications you are taking and for what condition you are taking them for: _____

_____

Have you ever:	Yes	No	Briefly Explain
Broken bones?	□	□	_____
Been hospitalized?	□	□	_____
Been in an auto accident?	□	□	_____
Had sprains/strains?	□	□	_____
Been struck unconscious?	□	□	_____

Insurance Information

Do you have health insurance? □ Yes □ No If yes, what company? _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Are we billing your auto insurance? □ Yes □ No

If yes, please provide:

Insurance company name: _____ Date of incident: _____

Contact Person: _____ Phone Number: _____

Claim Number: _____ Claim Address: _____

Please complete the following for any complaints and/or any conditions you may be experiencing

Location of complaint #1 (ie: low back, neck, mid back, etc.)_____

Date started: _____ Nature of Injury: □ Automobile □ Work related □ Other

Please describe: _____

Have you ever had this condition before? □ Yes □ No If yes, when? _____

On what side are you experiencing your condition? □ Right side □ Left side □ Both Sides □ Center

On a scale of 1 to 10, rate your level of pain: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, rate your affected activity level: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

□ Constantly (76% - 100%) □ Frequently (51% - 75%) □ Occasionally (26% - 50%) □ Intermittently (0% - 25%)

Describe the intensity of your pain □ Minimum □ Mild □ Moderate □ Severe □ None

Describe the nature of your pain:

□ Dull ache □ Tightness □ Tingling □ Sharp □ Stabbing □ Throbbing
□ Shooting □ Radiating □ Burning □ Numb □ Stiffness □ Other

What makes your pain better?

□ Chiropractic Therapy □ Sleep/rest □ Heat □ Ice □ Massage Therapy □ Stretching □ Pain Medications
□ Physical Therapy □ Therapy □ Nothing

Location of complaint #2 (ie: low back, neck, mid back, etc.)_____

Date started: _____ Nature of Injury: □ Automobile □ Work related □ Other

Please describe: _____

Have you ever had this condition before? □ Yes □ No If yes, when? _____

On what side are you experiencing your condition? □ Right side □ Left side □ Both Sides □ Center

On a scale of 1 to 10, rate your level of pain: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, rate your affected activity level: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

□ Constantly (76% - 100%) □ Frequently (51% - 75%) □ Occasionally (26% - 50%) □ Intermittently (0% - 25%)

Describe the intensity of your pain □ Minimum □ Mild □ Moderate □ Severe □ None

Describe the nature of your pain:

□ Dull ache □ Tightness □ Tingling □ Sharp □ Stabbing □ Throbbing
□ Shooting □ Radiating □ Burning □ Numb □ Stiffness □ Other

What makes your pain better?

□ Chiropractic Therapy □ Sleep/rest □ Heat □ Ice □ Massage Therapy □ Stretching □ Pain Medications
□ Physical Therapy □ Therapy □ Nothing

Location of complaint #3 (ie: low back, neck, mid back, etc.)_____

Date started: _____ Nature of Injury: □ Automobile □ Work related □ Other

Please describe: _____

Have you ever had this condition before? □ Yes □ No If yes, when? _____

On what side are you experiencing your condition? □ Right side □ Left side □ Both Sides □ Center

On a scale of 1 to 10, rate your level of pain: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, rate your affected activity level: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

□ Constantly (76% - 100%) □ Frequently (51% - 75%) □ Occasionally (26% - 50%) □ Intermittently (0% - 25%)

Describe the intensity of your pain □ Minimum □ Mild □ Moderate □ Severe □ None

Describe the nature of your pain:

□ Dull ache □ Tightness □ Tingling □ Sharp □ Stabbing □ Throbbing
□ Shooting □ Radiating □ Burning □ Numb □ Stiffness □ Other

What makes your pain better?

□ Chiropractic Therapy □ Sleep/rest □ Heat □ Ice □ Massage Therapy □ Stretching □ Pain Medications
□ Physical Therapy □ Therapy □ Nothing