New Patient Intake Form

Please complete prior to your new patient visit.

Analysis / Examination:

As a part of the analysis, examination, and testing procedures we may recommend:

___ vital signs & palpation
___ range of motion testing
___ postural analysis
___ muscle strength testing
___ basic neurological testing
___ orthopedic testing
___ radiographic studies
___ nutrition and supplementation
___ blood work analysis
___ Shockwave therapy
___ genetic testing

Treatment:

FHS care is directed towards the cause of dysfunction in the body and not to eliminate or mask symptoms. By no means do we claim to prevent, treat, or cure any specific ailments, as neither doctor nor medication can truly heal the body.
True healing takes place from within the body, not by external forces. Through physical evaluation, chiropractic care, patient-centered education & guidance we offer manageable steps to help regulate the body. By using specific manual therapy techniques, active rehabilitation, and customized nutritional and dietary interventions combined with lifestyle modifications the body will do what it was meant to do…heal itself. We also utilize extracorporeal shockwave therapy to help facilitate and speed up the healing process.

If you are currently on prescription medication, we ask you not to make any changes, nor go off of these medications without first consulting with your primary care physician or prescribing doctor. It is the responsibility of your prescribing doctor to make any medication changes and to work with us toward helping you become as drug-free as possible.

WANT US TO SHARE YOUR PROGRESS WITH YOUR PHYSICIAN?

If so, please list the name and/or contact information of your treating physician.

_____ Physician's Name

_____ Physician's Office

_____ Phone Number

_____ Physician's Email

Patient Intake Form

Patient Information:

Legal Name: _____ Phone:_____
First MI Last

Address: _____City:_____ State: _____Zip: _____

Age: _____Birth Date:_____ ***Pregnant?*** Y / N **Due Date:**_____

Sex (circle): Female /Male / Intersex / DSD

Email Address: _____

Cell Phone: _____

I prefer to be contacted (circle): text / call / email / other ***and/or*** Cell / Home

Employer: _____ Occupation: _____

I am (circle) Under Age18 / Single / Married / Partnered / Divorced / Widowed / Separated / Decline to Answer

Partner/ Spouse's Name: _____Partner /Spouse's Date of Birth:_____

Emergency Contact: _____ Emergency Contact Phone Number:_____

Consent for Treatment

Assignment & Release *- By signing below, I authorize Fredrickson Health Solutions to collect payment for services rendered. I understand that I am responsible for the amount owed for service rendered, for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*
By signing below, I give my consent for examination and the performance of any tests or procedures needed. If a patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed _____ Printed Name _____

Date_____

Health Questionnaire

Patient Information

Today's Date:_____

Patient Name: _____ **Date of Birth**:_____

Height:_____**Weight**: _____ **Normal Blood Pressure**: _____

List all *prescription,* non prescription *medications* and other *supplements* you take as well as the *associated condition*:

_____

_____

_____

Birth Control? Y/ N _____

List any *surgeries* or *hospitalizations* you have had complete with *the month and year for each*:

_____

_____

_____

List anything you are allergic to:

_____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? □ Yes □ No **Hours per week** _____**What activity(s)?**_____

_____

_____

Are you dieting? □ Yes □ No Since: **Do you smoke?** □ Yes □ No _____ packs per day

How many years have you been smoking?_____ **Do you drink alcoholic beverages?** □ Yes □ No ___drinks per day

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics □ Brace / Supportwear:
_____

FOR WOMEN: Are you pregnant or nursing? □ Yes □ No **If pregnant, How many weeks?** _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? *(Circle one)* Constantly Frequently Occasionally Intermittently

Describe your symptoms? *(circle all that apply)* Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? *(Circle one)* Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?

Have you experienced these symptoms in the past?

History of Treatment

Primary care physician: **_____PCP Phone:_____**

Date last seen: **_____May we update them on your condition?** □ Yes □ No

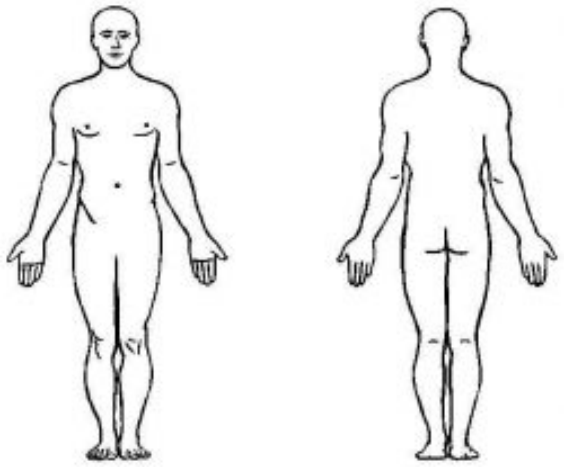
Have you seen a chiropractor before? □ Yes □ No **How did you hear about us? _____**

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

Description of Condition:

Mark any area(s) of discomfort on the body chart using the following key:

A =Ache
N =Numbness
B = Burning
T = Tingling
S = Stiffness
O = Other



On a scale of 1-10 how intense are your symptoms? 1 is no pain, 10 is the worst pain imaginable.

Last 24 hours:_____ Past week:_____

How often do you experience your symptoms? (Please Circle)

Constantly Frequently Occasionally Intermittently

How much have your symptoms interfered with your usual daily activities? (Please Circle)

Not at all A little bit Moderately Quite a bit Extremely

In general, would you say your overall health right now is: (Please Circle)

Excellent Very good Good Fair Poor

QUADRUPLE VISUAL ANALOGUE SCALE:

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

1. What is your pain RIGHT NOW?

---

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

---

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST **(How close to "0" does your pain get at its best)?**

---

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

5. What is your pain AT ITS WORST **(How close to "10" does your pain get at its worst)?**

---

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Have these symptoms changed in the quality of pain or the duration of pain recently? If so, please explain.

What are your goals for treatment? Please describe short term and long term goals.

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

Previous History Concerns

Please carefully read the following. *If you are unsure, check the "?" box.*

☐ Yes ☐ No ☐ ? A past history of cancer?
☐ Yes ☐ No ☐ ? Unexplained weight loss?
☐ Yes ☐ No ☐ ? Does your pain fail to improve with rest?
☐ Yes ☐ No ☐ ? Are you over 50 years old?
☐ Yes ☐ No ☐ ? Failure to respond to a course of conservative care? (lasting 4-6 weeks)

☐ Yes ☐ No ☐ ? Have you had spinal pain greater than 4 weeks?
☐ Yes ☐ No ☐ ? Prolonged use of corticosteroids (such as an organ transplant Rx)?
☐ Yes ☐ No ☐ ? Intravenous drug use?
☐ Yes ☐ No ☐ ? Current or recent urinary tract, respiratory tract or other infections?
☐ Yes ☐ No ☐ ? Immunosuppressive medication and/or condition?

☐ Yes ☐ No ☐ ? History of significant trauma?
☐ Yes ☐ No ☐ ? If over 50 years old, history of minor trauma?
☐ Yes ☐ No ☐ ? History of osteoporosis (soft bones)?
☐ Yes ☐ No ☐ ? Are you over 70 years old?

☐ Yes ☐ No ☐ ? Acute onset urinary infection or overflow incontinence (wet underwear)?
☐ Yes ☐ No ☐ ? Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
☐ Yes ☐ No ☐ ? Saddle paresthesia (numbness in the groin region)?
☐ Yes ☐ No ☐ ? Global or progressive muscle weakness in the legs (legs give out)?

Additional Patient Comments/Concerns:

For the conditions below, please indicate if you have had the condition in the past or if you presently have the condition:

Past	**Present**	**Condition**	*Past*	**Present**	**Condition**	*Past*	**Present**	**Condition**
		Abdominal Pain			Elbow/upper arm pain			Liver/Gallbladder Disorder
		Abnormal Weight gain/loss			Epilepsy			Loss of Bladder Control
		Allergies Headache			Excessive thirst			Low back pain
		Angina			Frequent Urination			Mid back pain
		Ankle/foot pain			General Fatigue			Neck pain
		Arthritis			Hand pain			Painful Urination
		Asthma			Heart attack			Prostate Problems
		Bladder Infection			Hepatitis			Shoulder pain
		Birth Control Pills			High blood pressure			Smoking/tobacco Use
		Cancer			Hip/upper leg pain			Stroke
		Chest Pains			HIV/AIDS			Systemic Lupus
		Chronic Sinusitis			Hormone Therapy			Thoracic Outlet Syndrome
		Depression			Jaw pain			Tumor
		Dermatitis/Eczema			Joint swelling/stiffness			Ulcer
		Dizziness			Kidney Stones			Upper back pain
		Drug/Alcohol Use			Knee/lower leg pain			Wrist pain

Additional comments you would like the doctor to know:

_____

_____

_____

Date: _____ **Date:** _____

Patient's signature: _____ **Doctor's signature:** _____

Financial Policy

Thank you for choosing Fredrickson Health Solutions, LLC as part of your health care team. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bill is considered part of your treatment and is due at the time that service is rendered. Please read our financial policy, initial each section and sign at the bottom prior to your treatment.

In an effort to provide the best quality care for each of our patients, we do not accept insurance at this time. As a result, we have adopted the following financial policies:

_____Our clinic has established a single fee schedule that applies to all patients for each service provided.

_____You may request a copy of your super bill to submit to your insurance company on your own behalf.

_____I agree to assume all financial responsibility and to keep my account current by paying for each visit at the time services are rendered.

Missed Appointments

It is the policy of **Fredrickson Health Solutions** to assess a **$25.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____*My initials here indicate that I understand the above missed visit policy.*

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature Date

Informed Consent to Care:

Doctors of Chiropractic who use manual therapy techniques such as highly specific manual therapy, myofascial release, active rehab exercises, kinesio-taping, cryotherapy, and spinal adjustments should advise patients that there are or may be risks associated with such treatment. In particular, you should note the following risks or complications:

Manual Therapy/Myofascial Release: local discomfort, skin reddening, superficial tissue bruising,release of emboli (rare), post treatment soreness, an increase in pain that may last up to 72 hrs or a shift in symptoms to different areas

Active Rehab Exercises: aggravation of present condition, blood pressure changes, increased heart rate

Kinesio-Taping and Cryotherapy: skin reactions including but not limited to itching, allergic reactions, hyperpigmentation, discoloration and blistering.

Sensitive Areas: I recognize the nature of my injury may require my doctor to perform treatment in or around sensitive areas and they will make every effort to safeguard my modesty and conceal the area.

I understand there have been reported cases of vertebral artery injury following ***cervical spine (neck) adjustments***. Vertebral injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on extremely rare occasions cause death. The possibility of such injury is extremely remote.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:**_____ **Date:** _____

Extracorporeal Shockwave Therapy Informed Consent

What is extracorporeal radial shockwave therapy?

Extracorporeal radial shockwave therapy (ESWT) is a series of high-energy percussions to the affected area. The shockwave is a physical sound wave “shock”, not an electric one.

How does it work?

1. Treatment produces an inflammatory response. The body responds by increasing metabolic activity around the site of pain. This stimulates and accelerates the healing process (promotes the remodeling of dysfunctional collagenous tissues, such as tendinopathies, trigger points, muscle strains, etc.).
2. Shockwaves break down scar tissue and/or calcification
3. Transmission of pain is diminished through neurologic mechanisms (nociception inhibition)

What are the benefits of Shockwave Treatment?

This therapy stimulates the body’s natural self-healing process. There is actually an immediate reduction of pain and improved range of motion. ESWT may also eliminate your need for surgery depending on the amount of instability present.

How long does the treatment last?
Approximately 2000 pulses are administered per treatment area (the duration of which is approximately 5 minutes). Some patients and/or conditions require more pulses and duration, depending on severity and chronicity (how long the condition or injury has existed).

Treatment Costs
Treatment cost is $125 per single session, or you have the ability to purchase a package of three at the discounted price of $300 per package or 6 treatments at the discounted price of $510 per package.

However, a treatment may cost more, depending on the number of pulses required and delivered. An additional 2000 pulses per treatment will cost $30. Again, the number of pulses depends on the severity, chronicity and location(s) of the condition(s). Any necessary increases will be discussed with you before treatment begins.

How many treatments will I need?
Normally three to six treatments are necessary at weekly intervals; there is a small possibility that 2 or more additional treatments may be necessary if your condition is very chronic and/or you have severely restricted joint range of motion (ie. Frozen shoulder). Should you not respond in this time, your case will be reviewed with the doctor to determine an appropriate referral. Success rates with ESWT are unparalleled (over 80-90% improvement).

Does the treatment hurt?
It is a short treatment (usually five to twenty minutes in duration) that may be uncomfortable at times. Most people can easily tolerate the procedure. However, if you cannot tolerate it, adjustments on the machine can decrease the pressure you feel.

Will it hurt after the treatment?
There may or may not be immediate pain, but some soreness or mild discomfort may be experienced 2-4 hours after the treatment. In some cases, it can last up to 48 hours and in very rare cases, the pain lasted up to 5 days. Some bruising and swelling can occur.

What should I do if I am in pain after the treatment?
The shockwave will trigger an inflammatory response, which is the body's natural process of healing. For this reason, do not use anti-inflammatory medications. Do not use heat. The pain should subside within 24 hours. Use Tylenol if necessary, provided you have no trouble with this medication.

What if it feels good after the treatment?
Even if it feels good, we recommend decreased activity for 48 hours following the treatment.

What is the success rate for this kind of treatment?
A successful treatment is considered as a patient having at least 75% reduction in pain within 3 months. Worldwide, success rates are around 80 to 90%.

What if it doesn't work for me?
Although the short-term effects alone are exceptional, the long-term benefits of this treatment may take up to 3-4 months. If after this time there has not been any marked improvement, you should see your doctor for further treatment options.

Are there contraindications and/or precautions?

Contraindications include:

- Coagulation disorders, thrombosis, heart or circulatory patients
- Use of anticoagulants, especially Marcumar, Heparin, Coumadin
- Tumor diseases, carcinoma, cancer patients
- Pregnancy: using the machine over the abdomen
- Polyneuropathy in case of diabetes mellitus
- Using the machine over open growth plates
- Cortisone therapy within the last 6-12 weeks

Side effects include: (These side effects generally abate after 5-10 days).

- Swelling, reddening, haematomas
- Petechiae, bruising
- Pain
- Skin lesions (especially after previous cortisone therapy)

Why am I asked to sign a consent form?

Pain can increase temporarily. Bruising and/or swelling are also possible. We want you to be informed of all aspects of this treatment. By signing below, you acknowledge that you understand and accept the risks, benefits, and cost of focus shockwave therapy; and consent to having this therapy administered.

Patient or Guardian's Signature _____Date_____