



# Franklin Back & Joint Care

www.backandjoint.net

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## CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us to determine if chiropractic can help you.

**PLEASE PRINT CLEARLY AND LEGIBLY.**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status: M S W D

Work Phone \_\_\_\_\_ Children # \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Hours Worked/Week \_\_\_\_\_

Referred By \_\_\_\_\_ Spouse's Work # \_\_\_\_\_

Email Address ( to receive our Health Newsletter) \_\_\_\_\_

Primary Care Physician & Location \_\_\_\_\_

Is it OK if we submit findings to your Primary Care Physician?    **YES**                      **NO**

### HEALTH INFORMATION:

Have you had previous chiropractic care? \_\_\_\_\_ When was last adjustment? \_\_\_\_\_

What is your Major complaint? \_\_\_\_\_

How did it start? \_\_\_\_\_

Other complaints? \_\_\_\_\_

How long have you had your major complaint? \_\_\_\_\_

Have you had this condition(s) in the past? \_\_\_\_\_ Last occurrence? \_\_\_\_\_

What aggravates your condition (ex: bending, lifting) \_\_\_\_\_

What helps relieve your condition (ex: heat) \_\_\_\_\_

Is this condition getting worse? (circle one)                      **YES**                      **NO**

Is the condition **CONSTANT** or does it **COME & GO?** (circle one)

Does the condition interfere with your (circle):    **Work**                      **Sleep**                      **Daily Routine**

Do you have any ankle, foot problems (flat feet, diabetes, short leg) \_\_\_\_\_

Do you currently wear heel lifts, shoe inserts or orthotics?                      **YES**                      **NO**

Have you ever had X-rays of your area of Major Complaint?                      **YES**                      **NO**

How long ago were these X-rays taken and where? \_\_\_\_\_

List surgical operations and year \_\_\_\_\_

Medications that you now take \_\_\_\_\_

Do you have a family history of any serious illness? \_\_\_\_\_

Have you been in an auto accident:                      **Past year**                      **Past 5yrs**                      **>5years**                      **No**

**PAIN & SYMPTOMATIC DESCRIPTION:**

Have you ever suffered from: (circle all that apply)

- Dizziness      Heart Trouble      Diabetes
- Arthritis      Headaches      Asthma

Circle your Major Complaint:

- Numbness/Tingling/Pins & Needles
- Dull Ache or Burning
- Sharp/Dagger-like pain
- Throbbing

Pain Scale: Please rate your pain as of today:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst)

**FEMALE PATIENTS:**

When was your last menstrual cycle: \_\_\_\_\_

Is there a CHANCE that you may be pregnant? \_\_\_\_\_

**INSURANCE INFORMATION:**

Is your condition due to an auto accident or job related injury?

Yes                  No

Do you have Health Insurance? Yes                  No

If yes, name of company \_\_\_\_\_ Policy# \_\_\_\_\_

Name and Date of birth of the policyholder being used \_\_\_\_\_

Are you covered by Medicare? Yes                  No

If yes, Health Insurance # \_\_\_\_\_

**Please Read the following statements and sign below:**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Franklin Back & Joint Care will prepare any necessary reports and forms used in making collections or for personal/legal needs. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care treatment, any fees for professional services rendered me will be immediately due and payable.

**Our X-Ray Policy:**

On many patients, we will require that we take x-ray views of the major complaint to rule-out medical pathology. It is also beneficial to look at the structure of the spine in order to better diagnose, adjust, and treat your specific problem. **You have the right to not have x-rays taken**, but understand that this may hamper our ability to correctly diagnose the cause of all your symptoms.

**I have read and agree to all above statements:**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ S.S.# \_\_\_\_\_

**HEALTH STATUS:**

Your Height & Weight: \_\_\_\_\_

Do you smoke? \_\_\_\_\_

Do you exercise? \_\_\_\_\_

Please mark your CURRENT areas of complaint on the figures below.

