



Dr. Franzen's New Patient Form

Date: \_\_\_\_\_ Account: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring MD: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_

Allergies \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Dr. Franzen's Notes

Gradual (date) \_\_\_\_\_

Injury (date) \_\_\_\_\_

Symptoms:

- |               |                                   |                                     |                                       |  |
|---------------|-----------------------------------|-------------------------------------|---------------------------------------|--|
| a) Pain       | Location _____                    |                                     |                                       |  |
| Quality:      | <input type="checkbox"/> Burning  | <input type="checkbox"/> Sharp ache | <input type="checkbox"/> Dull ache    | <input type="checkbox"/> Sore <input type="checkbox"/> Knifelike   |
| Duration:     | <input type="checkbox"/> Constant |                                     | <input type="checkbox"/> Intermittent |  |
| Exacerbation: | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking    | <input type="checkbox"/> Sitting      | <input type="checkbox"/> Lying <input type="checkbox"/> Reaching <input type="checkbox"/> Gripping <input type="checkbox"/> Extending <input type="checkbox"/> Flexing |
| b) Swelling   | <input type="checkbox"/> Yes      | <input type="checkbox"/> No         | e) Locking                            | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| c) Grinding   | <input type="checkbox"/> Yes      | <input type="checkbox"/> No         | f) Giving Way                         | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| d) Popping    | <input type="checkbox"/> Yes      | <input type="checkbox"/> No         | h) Neurological                       | <input type="checkbox"/> Yes <input type="checkbox"/> No   |

Sleep Problems? \_\_\_\_\_

Motor Vehicle Accident:  Yes  No

Seat belt:  Yes  No

Air Bag:  Yes  No

Driver  Passenger

Impact:  Front  Rear  Corner

History of Previous Problems: \_\_\_\_\_

Tests:  X-Ray  MRI  CT  Other \_\_\_\_\_

Treatments:

Surgery \_\_\_\_\_ Meds \_\_\_\_\_  
 Chiropractor \_\_\_\_\_ PT/OT \_\_\_\_\_  
 Drums \_\_\_\_\_ Cast \_\_\_\_\_  
 Injections \_\_\_\_\_

Work:

Type \_\_\_\_\_  
 Missed Time \_\_\_\_\_  
 Job Affected \_\_\_\_\_



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DATE: \_\_\_\_\_

ACCT #: \_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced  Widowed

Are you employed?  Yes  No Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact (not living with you): \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**SPOUSE/PARENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Are you employed?  Yes  No Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**ALL PATIENTS: PLEASE FILL OUT HEALTH INSURANCE SECTION**

Health Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

IS THIS WORKER'S COMP? IF SO, PLEASE COMPLETE:

Employers \_\_\_\_\_ Name of W/C Carrier \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Claim#: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

IS THIS AUTO? IF SO, PLEASE COMPLETE:

Name of Auto Insurance Co.: \_\_\_\_\_ Telephone: \_\_\_\_\_

Claim Office Address: \_\_\_\_\_ Claim/Policy: \_\_\_\_\_

\_\_\_\_\_ Date of Accident: \_\_\_\_\_

**NOTICE**

Interest may be charged on all accounts which are transferred to collections at a rate of 1 1/2% per month, annual rate of 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges if levied

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Dr. Franzen's New Patient Form

**PATIENT HISTORY**

Please PRINT and fill out completely

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hand Dominance  Left  Right

**HISTORY OF INJURY**

Did the problem result from a specific injury?  Yes  No Injury/Accident date: \_\_\_\_\_

Did your problems begin following:  Work Injury?  Motor Vehicle Accident? What State? \_\_\_\_\_

How did you get injured? \_\_\_\_\_

If neither, how long have you had the condition? \_\_\_\_\_

Please rate your pain on a scale of 1 to 10 (10 being the most painful): \_\_\_\_\_

Is the pain:  Constant  Occasional  Sharp  Dull  Aching  Stabbing  Throbbing

What symptoms are you experiencing:  Locking  Catching  Giving Way  Popping  Grinding  Other

What, if anything, makes you symptoms better? \_\_\_\_\_

What, if anything, makes you symptoms worse? \_\_\_\_\_

Have you seen another physician for this injury?  Yes  No

If yes, who? \_\_\_\_\_

What treatments have you tried?  Nothing  Physical Therapy  Exercise  Acupuncture

Chiropractic  Injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)

Medications \_\_\_\_\_  Other: \_\_\_\_\_

Test	Date (month/year)	What facility? (clinic/hospital)
<input type="checkbox"/> X-ray	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Regular Exercise.  Yes  No Type of exercise and activity you enjoy: \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please check any previous surgical procedures, list the date and describe surgery:

- Appendectomy  Hernia repair  Arthroscopy lower extremity  Upper extremity
- Spine/Back surgery  Heart surgery  Total Joint Replacement  Fracture Repair
- Other: \_\_\_\_\_



Dr. Franzen's New Patient Form

Health History - page 2

Name: \_\_\_\_\_ Practitioner's Initials: \_\_\_\_\_

**SOCIAL HISTORY**

Special Diet:     Yes     No    Any Restrictions? \_\_\_\_\_  
 Tobacco Use     Yes     No    Type: \_\_\_\_\_ Duration \_\_\_\_\_ Quit Date \_\_\_\_\_  
 Alcohol Use     Yes     No    Frequency: \_\_\_\_\_  
 Drug Use:         Yes     No    Frequency: \_\_\_\_\_  
 Caffeine Use:     Yes     No    Frequency: \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medications?     Yes     No     NO KNOWN DRUG ALLERGIES  
 Are you allergic to:    Sulfa     Yes     No    Latex     Yes     No  
 Please list all medications that you are allergic to: \_\_\_\_\_

**MEDICAL HISTORY**

Please check current or previous medical conditions:

- Anemia                                     Depression                                 Hepatitis A or B                             Osteoporosis
- Arthritis                                     Diabetes                                     High Blood Pressure                       Rheumatoid Arthritis
- Asthma                                       Emphysema                                 HIV     Stroke/Seizures
- Blood Clots                                 Heart Disease                               Irregular Heartbeat                       Thyroid
- Cancer                                       Liver Disease                                Chemical Dependency and/or Alcoholism
- Other \_\_\_\_\_

Have you ever had a blood transfusions?     Yes     No    If yes, when? \_\_\_\_\_

**MEDICATIONS**

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other the counter medications. Include Vitamin, Mineral and Herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**GASTROINTESTINAL HISTORY**

Do you have a history of Peptic Ulcer Disease?     Yes     No    If yes, when? \_\_\_\_\_  
 Do you have a history of GI, stomach bleed?     Yes     No    If yes, when? \_\_\_\_\_  
 Do you take any medications for your stomach?     Yes     No    (Please include over the counter medications, i.e. Pepcid, Tums, Zantac, etc., dosage and frequency.) \_\_\_\_\_

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include over the counter medications such as Advil, Aleve and previously prescribed medications, such as Celebrex and Vioxx. List all you have tried.) \_\_\_\_\_



Dr. Franzen's New Patient Form

Health History - page 3

Name: \_\_\_\_\_

Practitioner's Initials: \_\_\_\_\_

**FAMILY HISTORY** Please check family history conditions:

- |                                      |  |                                       |   |
|--------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke/Seizures      |

Please describe any immediate family history of medical problems: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check the "NONE" box.

- |                               |   |  |   |   |   |
|-------------------------------|---|--|---|---|---|
| 1. Constitutional/<br>General | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Weight loss   | <input type="checkbox"/> Weight Gain  | <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Chronic Fatigue  |
| 2. Eyes                       | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Vision Change   | <input type="checkbox"/> Glasses/Contacts                                     | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> Glaucoma   |
| 3. Ears, Nose,<br>Throat      | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Loss of hearing                                       | <input type="checkbox"/> Seasonal allergies                                   | <input type="checkbox"/> Sinus pain     | <input type="checkbox"/> Ringing  |
| 4. Cardiovascular             | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Chest pain  | <input type="checkbox"/> Edema  | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Palpitations   |
| 5. Respiratory                | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Asthma  | <input type="checkbox"/> Wheezing   | <input type="checkbox"/> Frequent Cough |   |
| 6. Gastrointestinal           | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Heart Burn<br><input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Indigestion<br><input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Acid Reflex    | <input type="checkbox"/> Ulcer Problems<br><input type="checkbox"/> GI, Stomach Bleed |
| 7. Musculoskeletal            | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Muscle Weakness                                      | <input type="checkbox"/> Joint Pain     | <input type="checkbox"/> Back Pain  |
| 8. Skin                       | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Rash  | <input type="checkbox"/> Ulcers   | <input type="checkbox"/> Scars          |   |
| 9. Neurological               | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Seizures   | <input type="checkbox"/> Numbness       | <input type="checkbox"/> Dizziness  |
| 10. Psychiatric               | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Depression  | <input type="checkbox"/> Crying   | <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Mood Swing   |
| 11. Endocrine                 | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Hypothyroid  | <input type="checkbox"/> Hyperthyroid   | <input type="checkbox"/> Hot flashes  |
| 12. Hematology                | <input type="checkbox"/> NONE<br><input type="checkbox"/> OTHER | <input type="checkbox"/> Easy Bruising   | <input type="checkbox"/> Bleeding   | <input type="checkbox"/> Anemia         |   |

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_