Dr. Edward Fratto, D.C • 540 Castro Street • San Francisco, CA 94114

Welcome to our office ! Please fill out the following for our records

Patient Information.

Date:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_(_____)_____ Work Phone:_(_____)_____

E-mail:_____ SSN:_____ Sex: M / F

Age:_____ Birth Date:_____ Weight:_____ Height:_____

Marital Status: S / M / P / D / W No.Children:_____

Referred By:_____

Occupation:_____ Employer:_____

Employer Address/City/state/zip:_____

Spouse´s / Partner´s Name:_____

Insurance Information

Insurance:_____ Insurance Phone:_(_____)_____

Insurance Address:_____ City:_____ State:_____Zip:_____

Insured´s Name:_____ Policy #:_____ Group #:_____

___ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Purpose of Visit:_____

When did your symptoms begin?:_____ Similar prior symptoms? Yes / No

List surgeries or illnesses:_____

Have you been under Chiropractic care before: Yes / No If Yes, Doctor:_____

Primary Medical Doctor Name / Address: _____

Is this condition due to (circle ALL that apply): WORK AUTO ACCIDENT SPORT INJURY

If Yes, Please provide date of injury:_____ Have you lost time from work: Yes / NO

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Please Check Current & Recurring Symptoms

Head:
- ☐ Headache
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bother eyes
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

Neck:
- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Grating sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

General:
- ☐ Nervous
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight

Low Back:
- ☐ Low back pain
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Pinched nerve in low back
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

Mid-Back:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid-back
- ☐ Muscle spasms

Abdomen:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

Shoulders:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can´t raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulder (R-L)
- ☐ Muscle spasms in shoulders

Arms & Hands:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pinched nerve in arm
- ☐ Pinched nerve in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

Hips, Legs & Feet:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Painful joints in toes
- ☐ Pain in foot (R-L)
- ☐ Pain in knee (R-L)

Chest:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs

Have you had X-rays before? ☐ Yes ☐ No When? _____

What areas were X-rayed? _____

Please sign and date the following statement:

I,_____, give Dr. Edward Fratto, D.C. permission to provide me with chiropractic care, soft tissue therapy and exercise rehabilitation. I will be financially responsible for payment of services rendered.

Signature: _____

Date: _____

Area of Complaint

Area of primary complaint: _____

Onset. When did you start feeling pain? How did it begin (accident, trauma, repetitive use)? Did it begin gradually or suddenly? Is this the first time you have experienced this pain or have you had it before? If you had it before, how often?

Provocative: What activities make the pain worse?

Palliative. What activities decrease the pain?

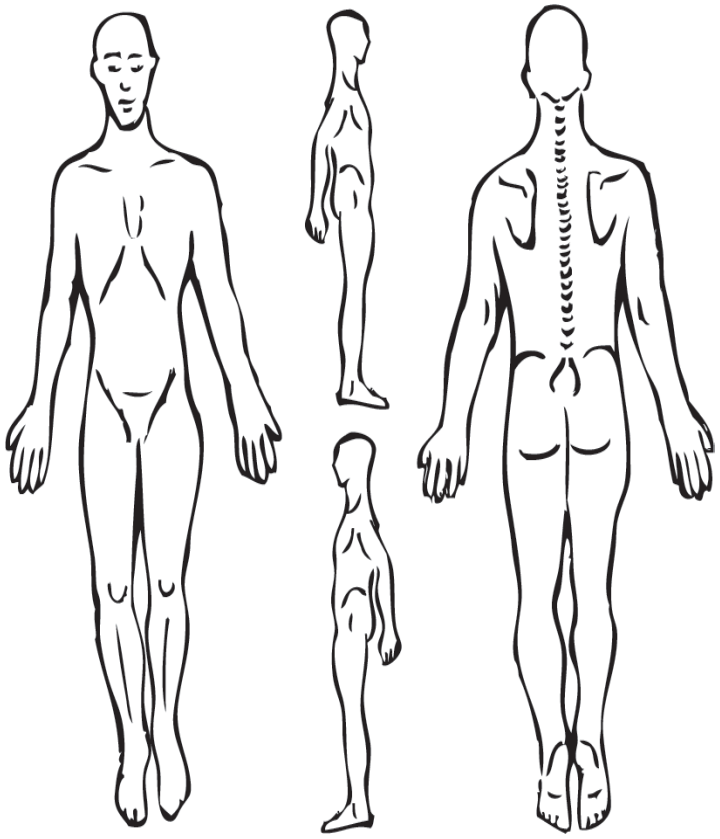
Quality. What is the quality of the pain (dull, achy, sharp, burning, electrical)?

Radiation. Is the pain well localized or does it radiate? If it radiates, to where?

Severity. On a 0-10 scale (0 no pain, 10 worst pain you have ever felt), rate your pain

Timing. Is your pain constant or intermittent? When is it at its worst (upon waking up, middle of the day, end of the day?

Please mark on the following figures the area of complaint:



Area of secondary complaint: _____

O _____

P _____

P _____

Q _____

R _____

S _____

T _____

Area of additional complaint: _____

O _____

P _____

P _____

Q _____

R _____

S _____

T _____

Dr. Edward Fratto,D.C.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Office of Dr.Edward Fratto, D.C, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or employer (if they are or may responsible for the payment of your services.)

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.
If you are not at home to receive an appointment reminder, a message maybe left on your answering machine.

Further, you have the right to be inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.
Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us provide care.
*If we are ordered by the courts or another appropriate agency any use or disclosed of your protected health care information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advice us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to your privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Office of Edward Fratto, D.C.

If you would like further information about our privacy policies and practice please contact: Office of Dr. Edward Fratto, D.C.

This notice is effective as of April 2003, this notice, and other alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____

Name (Printed please) Signature Date

if you are a minor, or if you are being represented by another party

_____

Personal Representative Printed Personal Representative Signature Date
Description of the authority to act on behalf of the patient.