WELCOME TO OUR OFFICE

PATIENT INTAKE FORM & PATIENT HEALTH QUESTIONNAIRE

FRYE Functional Health Center

3809 South State Route 159 Glen Carbon, IL 62034
618-692-1800

Patient Information			**Acct. #**		
Last Name:	First Name:	MI:	Date of Birth: / /	Age:	Sex: M / F
Street Address:		City:		State:	Zip Code:
Home Phone: ( )	Work Phone: ( )		Cell Phone: ( )		
Email Address:			Marital Status: Single / Married / Divorced / Other		
Employment Status: Employed / Retired / Full-Time Student / Other			Who Referred You To Our Office?		
Person To Contact In Case Of An Emergency:		Relationship:	Phone #: ( )		
Primary Care Physician:		Address:	Phone #: ( )		

Insurance Information		
Is your injury a result of: [ ] Work / Employment	[ ] Automobile Accident	Social Security #:
Primary Insurance Company:	Secondary Insurance Company:	[ ]Copies of Insurance Cards Provided

HIPAA	
I have received the privacy policy of FRYE Functional Health Center and understand how my health information is used and protected in this office.	
According to HIPAA, FRYE Functional Health Center is not allowed to release any health information to spouses, significant others, parents (unless patient is a minor), children, friends, employers, and/or other family members unless we have written consent by our patient. Please list the name of the person/ persons with whom FRYE Functional Health Center can share your health information with:	
Person #1:	Person #3:
Person #2:	Person #4:
[ ] At this time I elect to not have anyone other than those persons listed above, my insurance company, health professionals and attorneys to know about my health information. I understand I can add names to this list at any time.	

AUTHORIZATIONS:

A. I agree that the information listed above is correct to the best of my knowledge.
B. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
C. I understand that as a courtesy, FRYE Functional Health Center will call my insurance company to verify my benefits. If the event they are unable to verify my benefits at the time of my first visit, I understand I am still financially responsible for any charges incurred, based on the terms of my insurance policy.
D. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
E. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.
F. I further agree that this Authorization and Assignment is irrevocable until all monies owed FRYE Functional Health Center are paid in full.

Patient Signature: **Date:**

CONSENT TO TREATMENT OF A MINOR: I, being the legal guardian, authorize Dr. Clinton Frye and/or Dr. Brooke Frye and whomever he or she may designate as assistants to administer treatment as necessary to my son/daughter/grandchild/other, _____ .

Guardian Signature: **Date:**

FOR OFFICE USE ONLY:
NP:
NA / NI:
NA / NI:
NA / NI:
NA / NI:
NA / NI:
NA / NI:

FRYE Functional Health Center
Patient Health Questionnaire

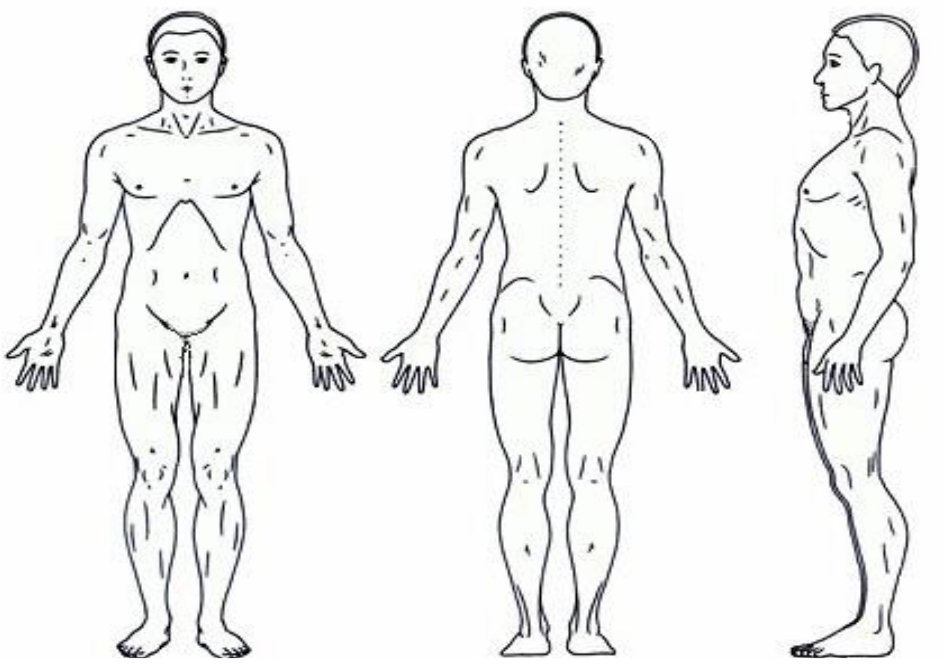
MAIN HEALTH ISSUES/COMPLAINTS
Please list the top 5 reasons for seeking care in our office:
1.
2.
3.
4.
5.

MUSCULOSKELETAL COMPLAINTS	
Complaint(s):	
When did it begin?	Is the condition getting progressively worse?
How did it begin?	
How often do you experience the issue (pain/discomfort/etc.)?	
Is it constant or does it come and go?	
On a scale of 1 (least amount of pain) to 10 (most severe pain), what would you rate the pain? Circle one: 1 2 3 4 5 6 7 8 9 10	
Does anything make it feel better? If so, what?	
Does anything make it feel worse? If so, what?	
Does it interfere with any of the following? Circle those that apply: Work Sleep Daily Routine Recreation	
Please circle those activities that are difficult/painful/uncomfortable to perform due to this condition: Sitting Standing Walking Bending Lying Down Turning your Head Coughing Sneezing Bearing Down	

Musculoskeletal– Conditions & Symptoms		
[ ] 1. Neck Pain	[ ] 6. Numbness	[ ] 11. Shooting/ Radiating
[ ] 2. Back Pain	[ ] 7. Tingling	[ ] 12. Fractures
[ ] 3. Muscle Pain/ Spasms	[ ] 8. Headaches	[ ] 13. Osteoporosis
[ ] 4. Joint Pain	[ ] 9. Prosthesis	[ ] 14. Hernia
[ ] 5. Arthritis; Choose Below:	[ ] 10. Osteopenia	
[ ] Rheumatoid		
[ ] Osteoarthritis		

Doctor's Notes

Please mark on the picture below where your problem areas are:



Doctor's Notes

Please answer the following to the best of your ability with the approximate date: (If you have a list that you would like us to copy, please let the front desk know)			**Doctor's Notes**
Allergies:	Surgeries/ Fractures/Dislocations:	Medications:	
Traumas (Physical or Emotional):	Nutritional Supplements/ Vitamins/ Minerals/ Herbs:		

Your Habits & Addictions and How Much You Partake			**Doctor's Notes**
[ ] 1. Alcohol-_____cans/day	[ ] 4. Soda-_____cans/day	[ ] 7. Food- Explain:	
[ ] 2. Chemical Dependency	[ ] 5. Cigarettes-____packs/day	[ ] 8. Other- Explain:	
[ ] 3. Coffee-_____cups/day	[ ] 6. Tea-_____glasses/day		

Cravings			**Doctor's Notes**
[ ] 1. Sugar	[ ] 4. Salt	[ ] 7. Carbohydrates	
[ ] 2. Water	[ ] 5. Ice Cream	[ ] 8. Bitter Chocolate	
[ ] 3. Protein	[ ] 6. Sweet/Milk Chocolate	[ ] 9. Other- Explain:	

Skin And Hair – Conditions & Symptoms			**Doctor's Notes**
[ ] 1. Rashes	[ ] 6. Eczema	[ ] 11. Ulcerations	
[ ] 2. Psoriasis	[ ] 7. Vitiligo	[ ] 12. Loss of Hair	
[ ] 3. Dandruff	[ ] 8. Itching	[ ] 13. Brown Spots on Skin	
[ ] 4. Change in hair texture	[ ] 9. Change in skin texture	[ ] 14. Other-Explain:	
[ ] 5. Pimples	[ ] 10. Hives		

Head, Eyes, Ears, Nose, And Throat – Conditions & Symptoms			**Doctor's Notes**
[ ] 1. Dizziness	[ ] 13. Teeth Problems	[ ] 24. Eye Pain	
[ ] 2. Eye Strain	[ ] 14. Gum Problems	[ ] 25. Cataracts	
[ ] 3. Color Blindness	[ ] 15. Sores on Lips or Tongue	[ ] 26. Spots in Eyes	
[ ] 4. Ringing in Ears	[ ] 16. Nose Bleeds	[ ] 27. Dry Mouth	
[ ] 5. Blurry Vision	[ ] 17. Tonsilitis	[ ] 28. Night Blindness	
[ ] 6. Glasses / Contacts	[ ] 18. Facial Pain	[ ] 29. Poor Vision	
[ ] 7. Sinus Problems	[ ] 19. Dry Throat	[ ] 30. Headaches – Explain:	
[ ] 8. Poor Hearing	[ ] 20. Tongue Coating/Cracking		
[ ] 9. Grinding Teeth	[ ] 21. Concussions	[ ] 31. Migraines- Explain:	
[ ] 10. Earaches	[ ] 22. Bad Breath		
[ ] 11. Mucus Buildup/Drainage	[ ] 23. Clicking Jaw	[ ] 32. Other- Explain:	

Cardiovascular & Respiratory– Conditions & Symptoms			**Doctor's Notes**
[ ] 1. High Blood Pressure	[ ] 11. Anemia	[ ] 21. Stroke	
[ ] 2. Dizziness	[ ] 12. Low Blood Pressure	[ ] 22. Difficulty Breathing	
[ ] 3. Blood Clots	[ ] 13. Fainting	[ ] 23. Bleeding Disorders	
[ ] 4. Heart Disease	[ ] 14. Pacemakers	[ ] 24. Irregular Heartbeat	
[ ] 5. Cough	[ ] 15. Pneumonia	[ ] 25. Coughing Blood	
[ ] 6. Emphysema/ COPD	[ ] 16. Bronchitis	[ ] 26. Tight Chest	
[ ] 7. Varicose Veins	[ ] 17. Cellulitis/Vasculitis	[ ] 27. Sleep Apnea	
[ ] 8. Chest Pain	[ ] 18. Cold Hands/ Feet	[ ] 27. Other- Explain:	
[ ] 9. Swelling in Hands/ Feet	[ ] 19. Asthma		
[ ] 10. Arterial Blockage	[ ] 20. Phlebitis		

Gastrointestinal– Conditions & Symptoms			**Doctor's Notes**
[ ] 1. Nausea / Vomiting	[ ] 7. Appendicitis	[ ] 13. Anorexia/ Bulimia	
[ ] 2. Gas - Belching	[ ] 8. Crohn's Disease	[ ] 14. Bloating	
[ ] 3. Gas – Lower Bowel	[ ] 9. Pain or Cramps	[ ] 15. Gluten Sensitivity	
[ ] 4. Constipation	[ ] 10. Rectal Pain	[ ] 16. Ulcers / Ulcer. Colitis	
[ ] 5. Diarrhea	[ ] 11. Bloody / Black Stool	[ ] 17. Gout	
[ ] 6. Hemorrhoids	[ ] 12. Sensitive Abdomen	[ ] 18. Other- Explain:	
19. Bowel Movements- Color:	Frequency:	Odor:	Texture/ Form:

Pregnancy & Gynecology– Conditions & Symptoms

[ ] 1. Vaginal Discharge
[ ] 2. Currently Pregnant
[ ] 3. Irregular Menstruation
[ ] 4. PMS
[ ] 5. Breast Lumps
[ ] 6. Painful Periods
[ ] 7. Blood Clots
[ ] 8. Currently Breastfeeding
[ ] 9. Cysts/ Fibroids
[ ] 10. Breast Pain with Period
[ ] 11. Vaginal Sores
[ ] 12. Premature Birth(s)
[ ] 13. Vaginal/Yeast Infections
[ ] 14. STDs
[ ] 15. Endometriosis
[ ] 16. Headache with Period
[ ] 17. Night Sweats
[ ] 18. Hot flashes

[ ] 19. Infertility Issues – Please explain:
[ ] 20. On Birth control Method(s):
[ ] 21. Age of First Period:
[ ] 22. # of Days Period Lasts:
[ ] 23. # of Days Cycle Lasts:
[ ] 24. Date of Last Period:
[ ] 25. Date Menopause began:
[ ] 26. Date of Last Pap Smear: Results:
[ ] 27. # of Pregnancies:
[ ] 28. # of Miscarriage(s):
[ ] 29. # of Child Birth(s):
[ ] 30. C-Section(s) – Why?
[ ] 31. Other – Explain:

Doctor's Notes

Genito-Urinary– Conditions & Symptoms

[ ] 1. Pain/ Burning on Urination
[ ] 2. Unable to Hold Urine
[ ] 3. Wake up to Urinate
[ ] 4. Urgency to Urinate
[ ] 5. Frequent Urination
[ ] 6. Kidney Stones
[ ] 7. Bladder Infections
[ ] 8. Impotency
[ ] 9. Blood in Urine
[ ] 10. STDs
[ ] 11. Kidney Disease
[ ] 12. Prostate Problems
[ ] 13. Other – Explain:

Doctor's Notes

General / Endocrine – Conditions & Symptoms

[ ] 1. Scarlet Fever
[ ] 2. AIDS/HIV Positive
[ ] 3. Diabetes/Insulin Resist.
[ ] 4. Thyroid Problems/Disease
[ ] 5. Insomnia
[ ] 6. Chills
[ ] 7. Cold Back/ Flanks
[ ] 8. Vertigo
[ ] 9. Bleed or Bruise Easily
[ ] 10. Sweat Easily
[ ] 11. Polio
[ ] 12. Heavy Appetite
[ ] 13. Heavy Sleep
[ ] 14. Rheumatic Fever
[ ] 15. Measles/Mumps
[ ] 16. Herpes
[ ] 17. High Chol./Triglycerides
[ ] 18. Cold Hands/Feet
[ ] 19. Localized Weakness
[ ] 20. Night Sweats
[ ] 21. Cold Abdomen
[ ] 22. Change in Appetite
[ ] 23. Cravings
[ ] 24. Strong Thirst
[ ] 25. Hot Flashes
[ ] 26. Chicken Pox
[ ] 27. Typhoid Fever
[ ] 28. Tumors/Growths
[ ] 29. Hepatitis: Type:_____
[ ] 30. Poor Appetite
[ ] 31. Fevers
[ ] 32. Poor Sleep
[ ] 33. Poor Coordination
[ ] 34. Tremors
[ ] 35. Fatigue
[ ] 36. Liver Disease
[ ] 37. Difficulty Falling Asleep
[ ] 38. Difficulty Staying Asleep
[ ] 39. Other – Explain:

Doctor's Notes

Neurchopsyological– Conditions & Symptoms

[ ] 1. Seizures/ Epilepsy
[ ] 2. Poor Memory
[ ] 3. Bad Temper
[ ] 4. Muscle Tremor/ Twitching
[ ] 5. Depression
[ ] 6. Multiple Sclerosis
[ ] 7. Concussion
[ ] 8. Mood Swings
[ ] 9. Suicidal Thoughts
[ ] 10. Anxiety
[ ] 11. Easily Stressed
[ ] 12. Parkinson's
[ ] 13. Suicidal Attempt(s)
[ ] 14. Treated for Emotional Imbalance – Explain:
[ ] 15. Other - Explain:

Doctor's Notes

*****As you will quickly learn, our practice has a premium focus on different aspects of alternative medicine and holistic healing. These include nutritional care and whole-food supplementation, acupuncture, chiropractic, and massage therapy. In the process of your initial history, consultation, exam, and/or future appointments the doctor may recommend any one (or a combination) of the following treatments and/or testing methods to properly evaluate and successfully treat your condition.*****

Please designate below which of the following treatments/testing options you are open to and willing to explore should the doctor(s) recommend them for you:

[ ] Chiropractic Care
[ ] Acupuncture
[ ] Hair Analysis
[ ] Saliva Testing
[ ] Dietary Changes
[ ] Nutritional Supplementation (Vitamins & Minerals)
[ ] Massage Therapy
[ ] SHAPE ReClaimed Homeopathic Program for weight loss, reducing inflammation, assisting in detoxification, endocrine (hormone) balancing.
[ ] I want the doctor to appropriately select what is necessary for my condition after my exam & consultation.

Please understand that even though you may not choose a certain option, if the doctor finds a specific treatment/ testing option necessary based on your body's needs, he/she will discuss this with you in more detail. I understand this and agree that all information I have provided is true to the best of my knowledge.

Patient Name Patient Signature Date