1. About you…

Today's date: ____/____/____

Full Name: ___________________________________

Male Female

How did you hear about us? ______________________________

What do you prefer to be called:___________________________

Address: ____

____

city state zip

Home Phone # (____)-_____-________

Work Phone# (____)-_____-________

E-mail: ___________________________

Date of birth: ____/____/____ Age: _____

Social security # : _____-____-______

Occupation:_____________ Employer:________________

Work address:____

____

city state zip

How long have you worked there?__________________________

Status: ()minor ()single ()married ()divorced ()separated ()widowed

Spouse's name:_________________ children? How many?______

2. About your insurance…

Ins. Company name:_________________

Policy #: __________________________

Group #: __________________________

Insured's name:_____________________

Relation t patient:___________________

Date of birth: ____/____/____

Insured's employer:_________________

I hereby authorize assignment of my insurance benefits to this office for services rendered. I understand that I am responsible for any balance not paid by my insurance. Signed:

____

3. About your account…

Person responsible:____________________

Billing address:________________________

(if other than above)___________________

payment method: ()cash ()check

4. About your problem…

Reason for today's visit: []emergency []new injury []old injury []wellness/preventive

What hurts you or seems to be the problem? ________________________________

How long have you had it?__________ How did it start?_____________________________

Rate your pain level with a mark in the correct box:

What is your pain **right now**?	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
What is your **typical or average** pain	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
What is your pain at its **worst**?	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Intense pain**

Did this problem occur due to an injury from: [] work, [] auto accident, []slip/fall, [] sports, []home, []lifting

Explain what happened:____

Is your condition getting []worse, []better, []staying the same?

Is your pain []constant or []intermittent (on and off)?

What does your discomfort feel like? []sharp, []dull, []achey, []pins/needles, []burning, []numb, []other_______

What things make your pain worse? []sitting [] standing [] walking []reaching []turning head []lying down
[]pressure []coughing []heat []twisting trunk []up/down stairs
[]other____

What things make your pain feel better? []rest, []ice, []heat, []sitting, []standing, []walking, [] lying down
[]medications []massage/rubbing area []other__________________

Is this problem interfering with your sleep? [] yes []no

Have you had this problem before? [] yes [] no. If so, is it the []same, []worse, or []not as bad?

For this problem have you seen: [] MD, [] DC(Chiropractor), [] Physical therapist, [] other________________

What did they do and did it help?____

Important! Please DRAW an image of your pain on the body diagram supplied on the reverse side.

In case of an emergency…

Who should we call?______________________ Relation?_______ Phone: ( )-____ -___________

Who is your family doctor?____________________ Phone: ( )-____ -________

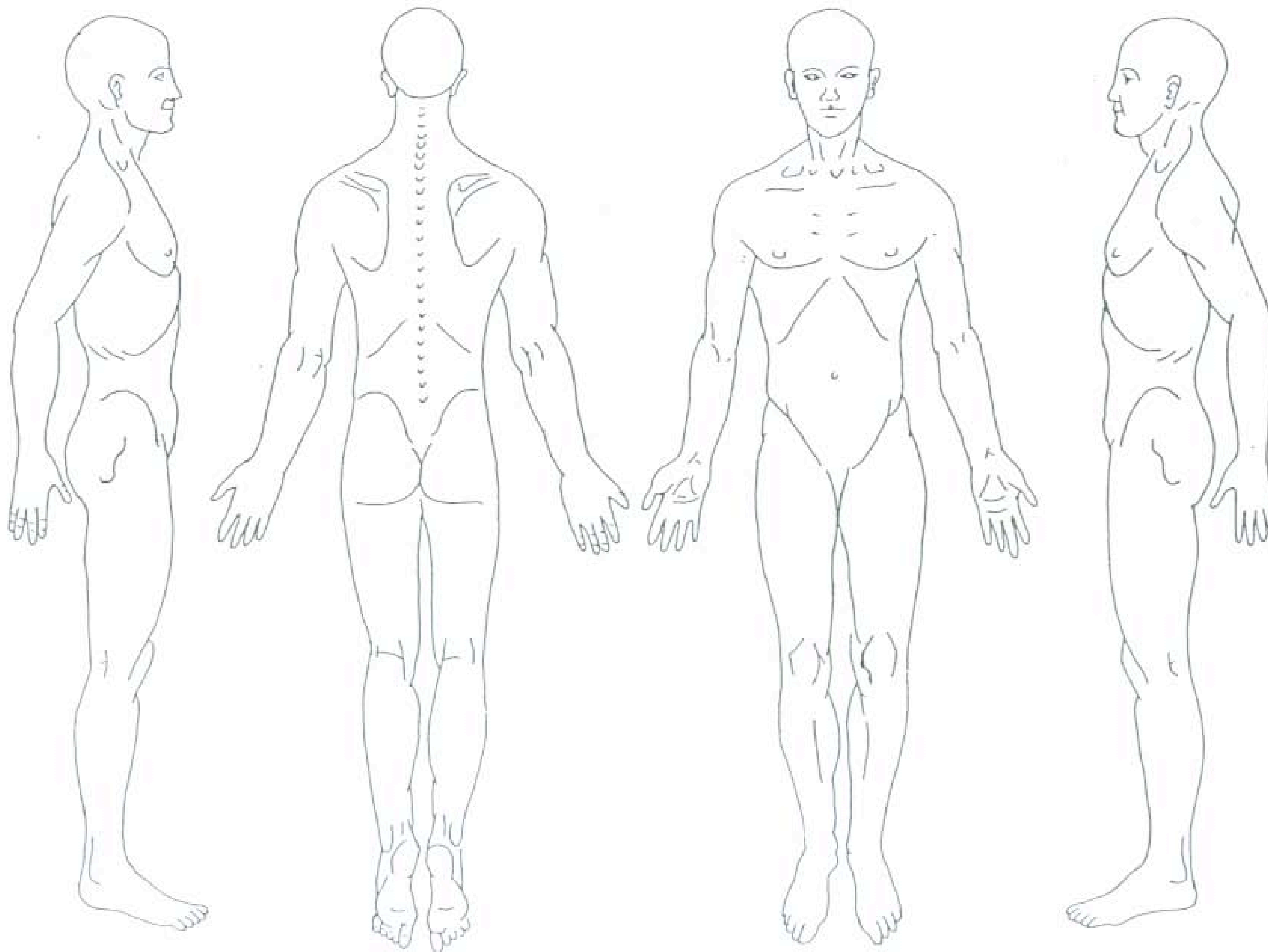
Dr. George DeFranca
508-835-2271

73 Central Street
W. Boylston, MA 01583

Name:________________________________ Date:____________

(Please shade in the drawing to show where you usually have pain. It is important to *shade* the drawing rather than using Xs or other marks to show where you have pain. Be as accurate as you can.)

Algometer ____________
Fibroquest ____________
FIQ ____________
Zung's ____________
Pain Dist. ____________



6. About your health history…

Are you taking any of the following medications: []prescription pain killers, []ibuprofen (motrin, advil) []muscle relaxants []steroids []cholesterol drugs, []blood thinners, []heart medications, [] blood pressure, [] insulin []thyroid hormone, []estrogen, [] anti-seizure medications, [] tranquilizers, [] anti-anxiety

Have you or do you have any of the following conditions:

[] alcoholism	[] diabetes	[] heart disease	[] polio	[] tuberculosis
[] anemia	[] epilepsy	[] multiple sclerosis	[] rheumatic fever	[] ulcers
[] arthritis	[] goiter	[] pleurisy	[] scarlet fever	[] venereal disease
[] cancer	[] gout/ thyroid illness	[] pneumonia	[] stroke	[] Lyme disease

General Symptoms

[] allergies	[] loss of sleep	[] swollen joints	[] skin/hair dryness	[] fatigue/ tired
[] dizziness/vertigo	[] weight loss/gain	[] swellings	[] hives	[] panic attacks
[] fainting	[] nervous/depressed	[] pins and needles	[] itching	[] anxiety
[] fever	[] numbness	[] weakness	[] skin rashes	[] chilly, always cold
[] headaches	[] sweats	[] easily bruise	[] varicose veins	[] hot flashes / flushing

Eye, ear, nose, throat symptoms

[] eye pain	[] ear pain/ ringing	[] sinus problems	[] bleeding gums	[] dry itchy eyes
[] blurred vision	[] deafness	[] nosebleeds	[] hard to swallow	[] stuffy nose
[] double vision/spots	[] ear/nose discharge	[] sore throats	[] enlarged thyroid gl	
[] failing vision	[] postnasal drip	[] hoarseness	[] enlarged glands	

Heart and lung symptoms

[] chest pain	[] rapid/slow beat	[] asthma	[] hard to breath	[] spit up blood	[] chest pressure or…
[] skipped beats	[] ankle swelling	[] chronic cough	[] wheezing	[] lots of phlegm	[] …strange feeling

Stomach, digestive symptoms

[] belching/gas	[] colon trouble	[] diarrhea	[] gall bl, trouble	[] yellow skin	[] nausea
[] colitis	[] constipation	[] heartburn/pain	[] hemorrhoids	[] liver trouble	[] vomiting

Urinary/ genital

[] blood in urine	[] hesitant/urgent	[] kidney stones	[] breast pain	[] hot flashes	[] irregular cycle
[] discharge	[] urination pain	[] prostate prob.	[] breast lump	[] painful periods	[] PMS
[] incr. frequency	[] can't control	[] cloudy urine	[] period cramps	[] excess flow	[] pregnant?

List any surgeries and when you have had them?____

List any past serious accidents, falls and when? ____

Family health history: ____

Do you smoke? []yes []no How much? ____packs per day

Do you drink alcohol? []yes []no How much? ____glasses/day
Do you use recreational drugs? [] yes [] no
Do you exercise? []yes []no How much and what type?_______________________________________

Do you take: []vitA, []vitB, []vitC, []calcium, []magnesium, []omega-3 oils []other____________________

Do you wear []foot orthotics []shoe lifts? How long?_________________

Have you seen a doctor of chiropractic before? []yes []no When?_________________

How would you rate your stress levels: []low, []moderate, []high, []very high

How do you release your stress? [] exercise [] meditate [] counseling [] other________________________

Dr. George DeFranca
Chiropractic Physician

7. Consent Form

Dear Patient,

Chiropractic examination and therapeutic procedures (including spinal manipulation, manual muscle therapy, stretching techniques, ultrasound, electrotherapy, and even exercise therapy) are considered safe and effective methods of care. Occasionally, however, as with any procedure intended to help, complications may arise. While the chances of experiencing complications are small, it is the practice of this office to inform our patients about them.

These complications are minor and, as a rule, self-limiting. They include, but are not limited to, regional soreness, inflammation, soft tissue injury, dizziness, headache, fatigue, and a temporary worsening of presenting symptoms. More serious complications are extremely rare. Please feel free to ask us about any of your concerns regarding the above.

I have read and understand the above statement regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result. I give my permission and consent to the procedures and treatments offered at this office.

Signed: ______________________________________ Date:________________

73 Central Street ***W. Boylston, MA. 01583***
ph.: 508.835.2271 ***f.: 508.835.3476***

Meet your doctor!

"I feel that a patient's health is affected by many diverse factors including diet, exercise, stress, posture, good physical conditioning, and a happy, healthy outlook on life. Attending to the mind, body, and spirit as integrated, rather than isolated, entities is paramount for optimal healing to occur. As a chiropractic physician I feel that good spine function is a prerequisite to normal nervous system function, which in turn will favorably affect a person's health. Our treatment goals are simple:
1, decrease pain initially; 2, improve function; 3, teach our patients about exercise and self-care methods; and 4, recommend preventive measures to aid in continued good function."

Dr. George G. DeFranca

Dr. George DeFranca is a graduate of the National College of Chiropractic and has been a practicing chiropractic physician since 1982. He is also an author, writer, and teacher. Dr. DeFranca lectures nationally as a seminar leader on the diagnosis and management of spinal and extremity pain syndromes and rehabilitation methods. He is an adjunct assistant professor of clinical sciences at the University of Bridgeport Chiropractic College where he developed a major component of their technique curriculum there. He also teaches doctors across the country about the violent and harmful effects of the typical golf swing, instructing them on a more "back-friendly" method.

A life-long student of chiropractic, Dr. DeFranca has made significant contributions to the chiropractic profession. He has had several papers published in peer-reviewed journals and has authored a text entitled *Pelvic Locomotor Dysfunction: a Clinical Approach* published by Aspen Publishers. In addition, he has written several chapters about the evaluation and manipulation of the spine and extremities as a contributing author in other edited texts.

Dr. DeFranca has had the privilege of being trained under many world renowned clinicians and authors. His approach to patient assessment is functional and holistic, stressing proper locomotor and neurologic function and rehabilitation through exercise and self-care. Because of his clinical experience, expertise in manual methods, his writings, and his teachings, he has established himself as an authority in his field worldwide, and as such, has earned the respect of his colleagues nationally. He feels that his greatest accomplishment is having delivered his three daughters at home.

"Dedicated to Excellence in the Art and Science of Modern Chiropractic"

73 Central Street
W. Boylston, MA 01583

508-835-2271
www.defranca.com

What you can expect in the Dr. DeFranca's office…

First visit: "Getting to know you."

We ask to you complete typical forms about yourself, how we can help you, and you're your preferred method of payment. After meeting Dr. DeFranca, he will conduct a consultation about your problem. The purpose of the consultation is to discuss the history of your condition and determine if in fact an examination needs to be done and to what extent.

"LET'S TALK"

"LOOK, LISTEN, FEEL, EXAMINE"

Dr. DeFranca is highly trained in assessing disturbances of the musculoskeletal system. As such, he will conduct an exam to assess nerve, muscle, and joint function in addition to posture, gait, and bodily movement patterns. Reflexes, muscle strength, and various tests will be used to assess you. You will find it interesting and educational at the same time. Many people state that they feel better even after the examination! Afterwards, an explanation of findings and treatment will be discussed and if appropriate, treatment will be rendered then or scheduled for another day.

Routine office Visits.

A follow-up visit based on an established treatment plan consists of a beginning, middle, and end. We ask that you remove your shoes, earrings, ect., and turn off your cell phone.

Beginning: opening assessment and brief exam.

Middle: treatment techniques, exercise instruction, advice/counseling.

End: closing comparison brief exam. Reschedule for next appointment or discharge.

"LET'S GET TO WORK"

Preventative Care

"TUNE-UPS"

Once pain is relieved and function is restored, a preventative level of treatment will be recommended. This entails regular periodic check-ups to maintain good function and to assess for future problems that may arise. Most patients love how good it feels to get their periodic "tune-ups".