FRANCIS CHIROPRACTIC CLINIC, S.C.

PATIENT INTAKE INFORMATION **DJF JMF**

NEW PATIENT / NEW CONDITION LAST VISIT____________________ REFERRED BY______________________

NAME: FIRST___________________MI_____LAST________________________S.S. #__________________ACCT________

ADDRESS____X-RAY #_________

CITY____STATE_______________ZIP____________________

PHONE: HOME__________________________CELL__________________________WORK___________________________

SEX M or F MARITAL STATUS________DATE OF BIRTH________________EMAIL______________________________

EMPLOYER:____OCCUPATION___________________________

SPOUSE OR PARENTS__________________________D.O.B._______________EMPLOYER____________________________

__________________________D.O.B._______________EMPLOYER____________________________

APPT. DATE & TIME____ MADE BY______________________________

CHIEF COMPLAINT____

____

HAVE YOU SEEN ANOTHER DR. FOR THIS CONDITION? ☐ Yes / ☐ No WHEN?_____________WHO?_________________

IS THIS AN ACCIDENTAL OR ON-THE-JOB TYPE INJURY? ☐ Yes / ☐ No WHEN?_________________________________

VERBAL AGREEMENT FOR X-RAYS FOR A MINOR? ☐ Yes / ☐ No

CHECKED PHOTO ID ( )

WILL THERE BE AN INSURANCE CLAIM INVOLVED? ☐ Yes / ☐ No INFORMED PATIENT TO CHECK INS. COVERAGE ( )

WORKER'S COMPENSATION ( ) GROUP POLICY ( ) *MEDICAID ( ) CASH PATIENT ( )
AUTO ACCID/PERSONAL INJURY ( ) PERSONAL POLICY ( ) *HIRSP ( )
MEDICARE ( ) MEDICARE SUPPLEMENT ( ) MEDICARE REPLACEMENT ( )

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE COVERAGE
INSURED'S NAME______________________	INSURED'S NAME______________________
ADDRESS______________________	ADDRESS______________________
______________________	______________________
SEX M F DOB______________________	SEX M F DOB______________________
TELEPHONE______________________	TELEPHONE______________________
SS #______________________	SS #______________________
INS. CO. NAME & #______________________	INS. CO. NAME & #______________________
POLICY #______________________	POLICY #______________________
GROUP NAME & #______________________	GROUP NAME & #______________________

NAME____DATE_________________________________

CHIEF COMPLAINT____

____

DATE THE PAIN STARTED?____

WHAT CAUSED THE PAIN?____

IS THE PAIN GETTING: BETTER WORSE STAYING THE SAME

HOW OFTEN DO YOU EXPERIENCE SYMPTOMS: CONSTANT FREQUENT OCCASIONAL

HOW WOULD YOU DESCRIBE SYMPTOMS: SHARP DULL NUMB SHOOTING BURNING TINGLING

WHAT HAVE YOU DONE TO RELIEVE THE PAIN? ICE HEAT MEDS EXERCISE OTHER________________

HAVE YOU EVER HAD THIS PAIN BEFORE? □ Yes / □ No IF YES, WHEN?____

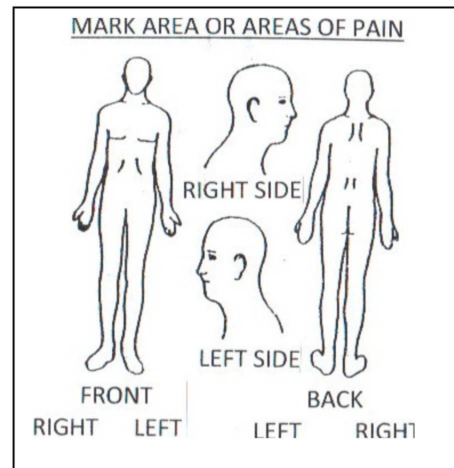
ACTIVITIES OF DAILY LIVING – CHECK THE ONES THAT ARE TROUBLESOME

- ☐ Bathing
- ☐ Bending
- ☐ Caring for Children
- ☐ Carrying Objects
- ☐ Climbing Stairs
- ☐ Concentrating
- ☐ Cleaning
- ☐ Crouching/Squatting
- ☐ Dressing
- ☐ Driving
- ☐ Eating
- ☐ Exercise/Sports
- ☐ Gardening
- ☐ General Mobility
- ☐ Balance
- ☐ Lifting
- ☐ Lying Down
- ☐ Moving Joints
- ☐ Yard Work
- ☐ Pushing/Pulling with Hands
- ☐ Reaching Up and Out
- ☐ Holding onto Objects
- ☐ Reading
- ☐ Running
- ☐ Sexual Activity
- ☐ Sitting
- ☐ Turning/Twisting
- ☐ Walking
- ☐ Working
- ☐ Sleeping
- ☐ Recreational Activity
- ☐ Traveling
- ☐ Other, specify____________________

Pain Scale – 10 Worst Pain – Circle One

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe Unbearable



DECEMBER 2013