FRANCIS CHIROPRACTIC
CLINIC AND WELLNESS CENTER

PATIENT INTAKE INFORMATION

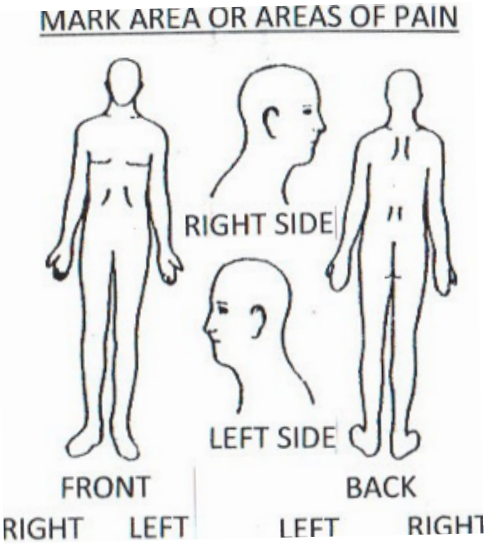
Name _____ Date _____ Preferred Name _____

EMAIL _____

Chief Complaint _____

_____

MARK AREA OR AREAS OF PAIN



Date Pain Started _____

Cause of Pain _____

_____

How Often do you experience Symptoms?

☐ Constant ☐ Frequent ☐ Intermittent ☐ Recurring
☐ Random ☐ Other _____

What have you done to relieve Pain?

☐ Ice ☐ Heat ☐ Medication ☐ Excercise
☐ Other _____

Describe Symptoms:

☐ Aching	☐ Deep	☐ Intolerable	☐ Stabbing	☐ Tight
☐ Annoying	☐ Diffused	☐ Pulling	☐ Stiff	☐ Tingling
☐ Burning	☐ Dull	☐ Sharp	☐ Throbbing	☐ Other

Does the Pain Radiate to other parts of your body?

☐ No ☐ Yes If yes, where? _____

Has the Pain:

☐ Improved ☐ Worsened ☐ Stayed the Same ☐ Some Lasting Relief

Pain Scale – 10 Worst Pain – Circle One

1	2	3	4	5	6	7	8	9	10
Mild			Moderate			Severe		Unbearable	

Activities of Daily Living - Check all that are troublesome

☐ None	☐ Employment	☐ Lifting	☐ Sleeping	☐ Yard Work
☐ General Mobility	☐ House work	☐ Driving	☐ Standing	☐ Shoveling
☐ Bending	☐ Exercise	☐ Sitting	☐ Walking	☐ Social Life
☐ Up & Down Stairs	☐ Twisting & Turning	☐ Push, Pull & Reaching	☐ Personal Care (Bathing, dressing, etc.)	