

# FRANCIS CHIROPRACTIC CLINIC

## PATIENT INTAKE INFORMATION

DJF JMF

NEW PATIENT/ NEW CONDITION \_\_\_\_\_ LAST VISIT \_\_\_\_\_ REFERRED BY \_\_\_\_\_

NAME \_\_\_\_\_ S.S. # \_\_\_\_\_ ACCT# \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_ X-RAY # \_\_\_\_\_

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? Y N WHEN? \_\_\_\_\_ WHO? \_\_\_\_\_

IS THIS AN ACCIDENTAL OR AN ON THE JOB INJURY? Y N WHEN? \_\_\_\_\_

VERBAL AGREEMENT FOR X-RAYS FOR A MINOR? Y N

WILL THERE BE AN INSURANCE CLAIM INVOLVED? Y N

CHECKED PHOTO ID ( )

INFORMED PATIENT TO CHECK INSURANCE COVERAGE ( )

WORKER'S COMPENSATION ( )

GROUP POLICY ( )

AUTO ACCID/ PERSONAL INJURY ( )

PERSONAL POLICY ( )

MEDICARE ( )

MEDICARE SUPPLEMENT ( )

### 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? \_\_\_\_\_

HAVE YOU EVER HAD THIS PAIN BEFORE? YES NO IF YES, WHEN? \_\_\_\_\_

MARK AREA OR AREAS OF PAIN

