

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 & YEAR _____ 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

* DO YOU NEED A REFERRAL? 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 ()

MEDICARE () MEDICARE SUPPLEMENT () MEDICARE REPLACEMENT () CARE PACKAGE ()

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE COVERAGE

INSURED'S NAME _____
ADDRESS _____

INSURED'S NAME _____
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

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

Pain Scale – 10 Worst Pain – Circle One

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

