FRANCIS
OPTIMAL PERFORMANCE
CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

(Please Print) Date: ____________

Name: ______________________________ SS: ____-____-_____ Phone: ____________

Address: ____________________________ City: ______________ State ______ Zip: ________

Birth Date: _________________ Age: _______ Sex: M F Marital Status: S M W D

Occupation: ______________________ Employed by: ____________________________

Driver's License #: __________________ Children: ____________________________

Work Phone: ________________ Address: ______________________________________

How were you referred to our office? ____________________________________

Have you ever been to a chiropractor before? ______ If so, when?
____

List your chief complaints in order of severity:

1. ____ For how long? ____________
2. ____ For how long? ____________
3. ____ For how long? ____________

List other doctors consulted for these conditions:

1. ______________________________ Address: ______________________________
2. ______________________________ Address: ______________________________

Primary Care Physician: _______________________ Phone: ____________________

Address: ____

If this is an injury:
1. Work related? _______ When _______ Have you reported it to your employer? ______

2. Auto accident? _______ When _______ Was there a police report? ______________

Females: Are you pregnant? Yes _____ No _____ Not Sure _____

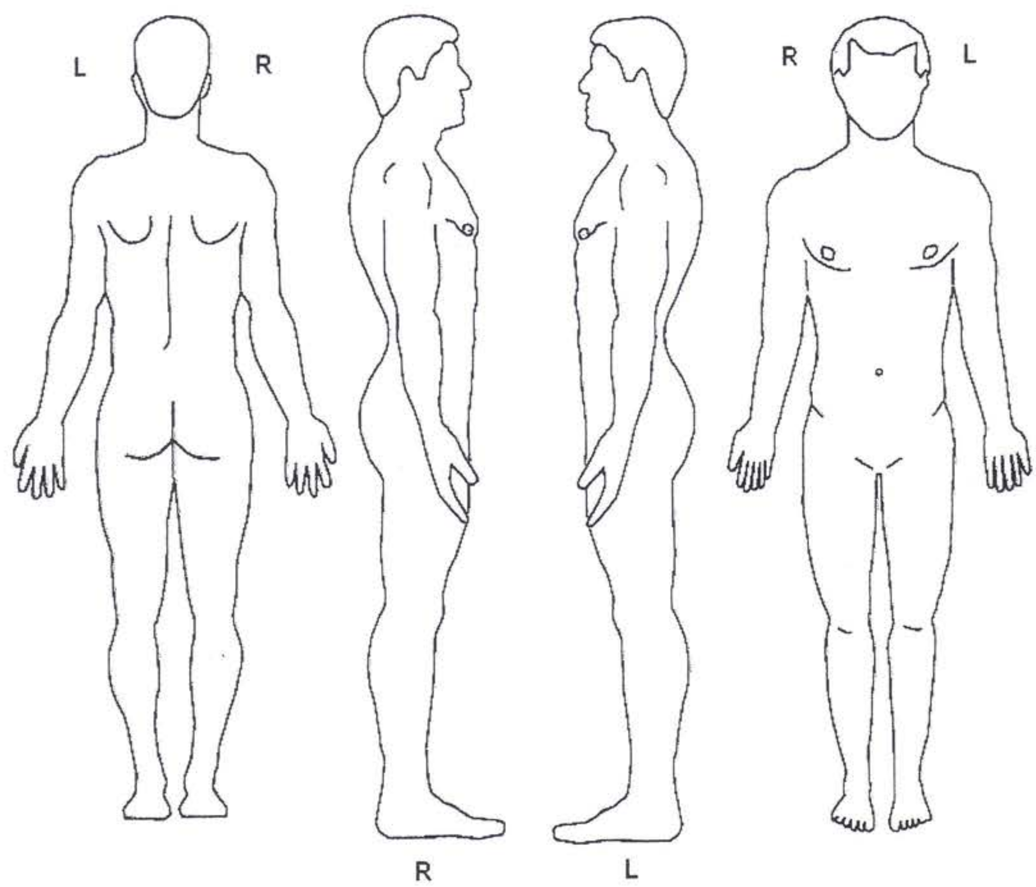
Height: ____________ Weight: _____________

PAIN DRAWING

Name: ______________________________ Date: ______________

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness --------	Pins & Needles 0000000	Burning Pain xxxxxxxxx	Stabbing Pain //////////	Aching Pain ((((((((



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**UNBEARABLE PAIN**
a) Right Now:----	0	1	2	3	4	5	6	7	8	9	10	________
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10	________
c) At Best ----	0	1	2	3	4	5	6	7	8	9	10	________
d) At Worst------	0	1	2	3	4	5	6	7	8	9	10	________

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History of Primary Complaint:

What is your primary complaint? ______________________

Have you ever had this complaint before? If so, when? ______________________

When did your symptoms begin, and ______________________

What was the mechanism of injury (be specific)? ______________________

____

What makes your symptoms better? ☐ ice ☐ heat ☐ rest ☐ exercise
☐ sitting ☐ standing ☐ other ______________________

What makes your symptoms worse? ☐ ice ☐ heat ☐ rest ☐ exercise
☐ sitting ☐ standing ☐ other ______________________

What is the quality of your pain? ☐ achy ☐ burning ☐ numb
☐ sharp/stabbing ☐ pins/needles ☐ other ______________________

Does the pain travel to other areas of your body?
☐ No, it is localized
☐ Yes, (where does it travel) ______________________

What is the timing of your pain? ☐ morning ☐ afternoon ☐ evening
☐ wakes you up at night ☐ constantly ☐ on and off

Do you have any other signs or symptoms that may seem unrelated to your chief complaints?
☐ No
☐ Yes (please list) ______________________

____

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History of Secondary Complaint:

When did your symptoms begin, and ____________________

What was the mechanism of injury (be specific)? ____________________

What makes your symptoms better? ☐ ice ☐ heat ☐ rest ☐ exercise
☐ sitting ☐ standing ☐ other ____________________

What makes your symptoms worse? ☐ ice ☐ heat ☐ rest ☐ exercise
☐ sitting ☐ standing ☐ other ____________________

What is the quality of your pain? ☐ achy ☐ burning ☐ numb
☐ sharp/stabbing ☐ pins and needles ☐ other ____________________

Does the pain travel to other areas of your body?
☐ No, it is localized
☐ Yes, (where does it travel) ____________________

When does your pain affect you the most? ☐ morning ☐ afternoon ☐ evening
☐ during sleep hours ☐ constantly ☐ on and off

History of Other Complaint:

When did your symptoms begin, and ____________________

What was the mechanism of injury (be specific)? ____________________

What makes your symptoms better? ☐ ice ☐ heat ☐ rest ☐ exercise
☐ sitting ☐ standing ☐ other ____________________

What makes your symptoms worse? ☐ ice ☐ heat ☐ rest ☐ exercise
☐ sitting ☐ standing ☐ other ____________________

What is the quality of your pain? ☐ achy ☐ burning ☐ numb
☐ sharp/stabbing ☐ pins and needles ☐ other ____________________

Does the pain travel to other areas of your body?
☐ No, it is localized
☐ Yes, (where does it travel) ____________________

When does your pain affect you the most? ☐ morning ☐ afternoon ☐ evening
☐ during sleep hours ☐ constantly ☐ on and off

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Past History:

Surgeries:
1. ________________ year ________ 2. ____________________ year ________
3. ________________ year ________ 4. ____________________ year ________

Traumas/MVA's:
1. ________________ year ________ 2. ____________________ year ________
3. ________________ year ________ 4. ____________________ year ________

Illnesses/ Infections/ Immunizations:
1. ________________ year ________ 2. ____________________ year ________
3. ________________ year ________ 4. ____________________ year ________

Medications and length of usage:
a) ______________ how long? ______ 2. ______________ how long? ________
3. ______________ how long? ______ 4. ______________ how long? ________

Medical Exams and Diagnostic Tests:
1. ________________ year ________ 2. ____________________ year ________
b) ________________ year ________ 4. ____________________ year ________

Any known allergies or food intolerances? ____________________

Family History:

Name any diseases or conditions that run in your family:

☐ Heart Dz. ☐ Cancer ☐ Stroke ☐ Diabetes ☐ High Cholesterol
☐ Hypertension ☐ Autoimmune Dz. ☐ other ________________________

Social History:

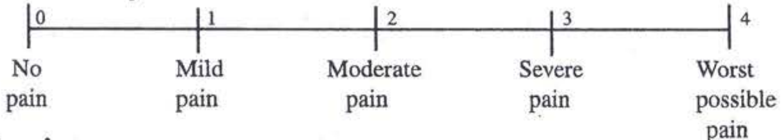
Fruits and Veggies (#/day): ____________ Supplements: ______________________
Water (cups/day) ____________________ Caffeine (drinks/day) ________________
Alcohol (drinks/week) ______________ Tobacco/Smoking (pack/day) ___________
Sleep (hours/night) ________________ Stress Levels _______________________
Exercise (days/week) _______________ Hobbies ____________________________

Functional Rating Index

For use with **Neck and/or Back Problems** only.

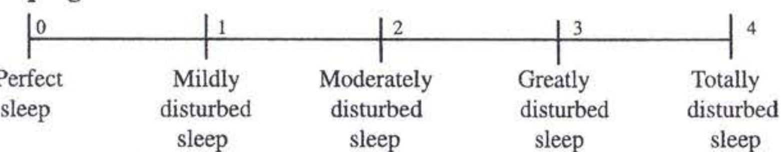
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



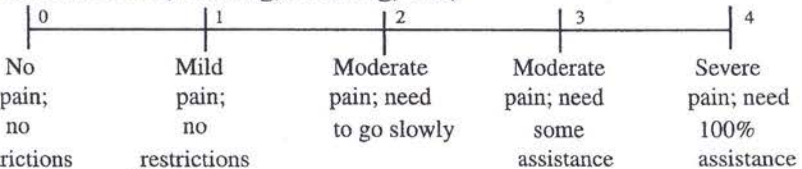
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



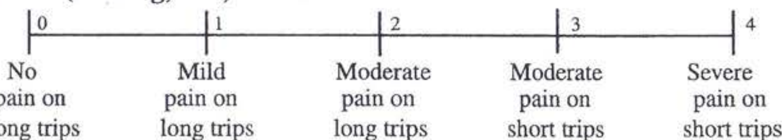
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



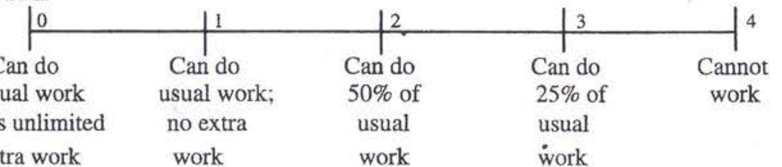
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



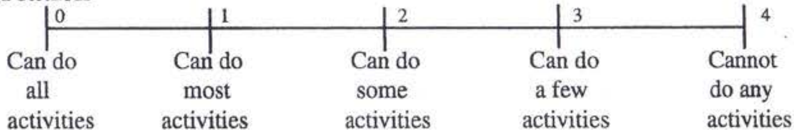
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



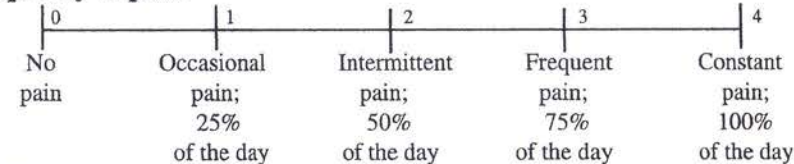
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



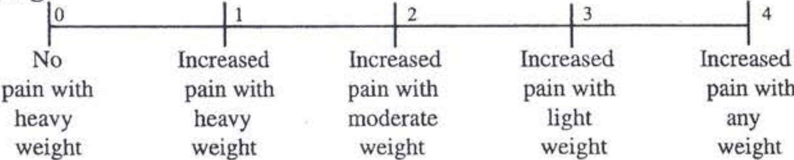
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



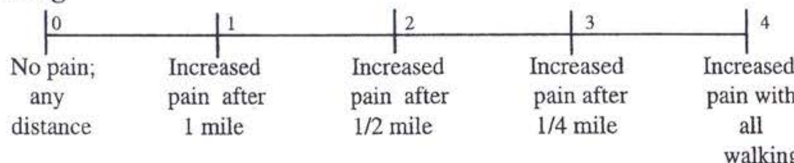
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



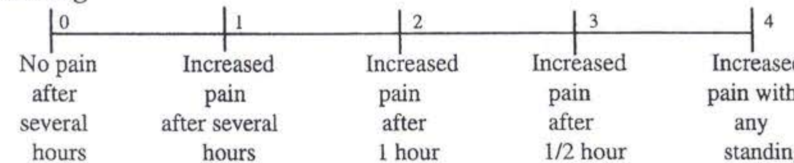
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________
PRINTED

Total Score ________

____
Signature

____
Date

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www.chiroevidence.com

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PRACTICE REQUIREMENTS

Protected Health Information (PHI), under the US Health Insurance Portability and Accountability Act (HIPAA), is any information about health status, provision of health care, or payment for health care that can be linked to an individual.

Francis Optimal Performance Chiropractic:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.

c) Is required to abide by the terms of this Privacy Notice.

d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

e) Will distribute any revised Privacy Notice to you prior to implementation.

f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice has been in effect since 4/15/03.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and agreement to its terms.

Print Name ______________________________

Patient's Signature ______________________________

Date ______________________________

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INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.

It is important that you realize that in this office, we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as such, our patients must understand and agree to the following:

1. That you must pay all deductibles in full, as well as inform us when your deductible has been met.
2. That co-pays and co-insurances must be paid at the time of service or at the beginning of each week.
3. That if the insurance company sends a payment to you, it is your responsibility to sign that check over to this office. You are responsible for all payments that are paid to you for service rendered in this office.
4. That you give Francis Optimal Performance Chiropractic authorization to release information to your insurance company concerning your care.
5. That you authorization your insurance company to pay Francis Optimal Performance Chiropractic directly for services rendered.
6. That you are ultimately responsible for payment of any and all services rendered; including re-exams, re-x-rays, and physical therapy.
7. That you are responsible to obtain the proper referrals and certifications for your care before being seen by the doctor. Failure to do so may result in limited coverage or no coverage and you would then be financially responsible for those fees.
8. If you present no insurance or you are unaware of your coverage, the office is not responsible to know your current status with your insurance company.

Your insurance is financially responsible for only those visits and care necessary to return you to your symptomatic improvement. Most insurance will not pay for spinal corrective care once we have reduced your symptoms. When you proceed with care, you will be financially responsible for visits not covered by your insurance. Insurance is not the responsibility of this office. Insurance is the complete responsibility of the patient. We do NOT credit patient accounts for previous dates of service.

This insurance assignment policy must be followed and we ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it and that you accept full responsibility.

Date: ___________

Patient's Name: ____

Patient's Signature: ____

Francis Optimal Performance Chiropractic
1800 Naamans Road, Suite 1
Wilmington, DE 19810
302-475-3200
302-475-2516 Fax

Release Authorization

I, ________________________________, request your office,
Patient Name

Dr.________________________________
____
____
Phone:_____________________________
Fax:_______________________________

to release all medical records to Dr. Michael Francis at the above-listed address.

Thank you,

____
Patient Signature

Date:_____________________________