Dr. Stacey Francis
Chiropractic Kinesiologist

20307 W. 12 Mile Road, Suite 105 | Southfield, MI 48076 | 248-213-1332

Date _____ Medicare _____

Name _____ Age _____ Birthday _____ M _____ F _____

Home Address _____ City _____ State _____ Zip _____

Phone: (home)_____ (work)_____ (cell)_____ Email_____

Marital Status: S _____ M _____ W _____ D _____ Spouse or Parent's Name _____

Person to contact in case of emergency _____ Emergency Contact Phone _____

Occupation _____ Employer & Address _____

Referred By _____ Have you seen a chiropractor before? Y_____ N_____ Height _____ Weight _____

Describe your MAJOR COMPLAINTS in order of their importance _____

_____

_____

State CAUSE OF CONDITION _____

State WHEN CONDITION FIRST STARTED _____

Before this date have you had the same or similar symptoms? Y _____ N _____ This condition is getting ... Worse _____ Better _____ Constant _____

What AGGRAVATES this condition? _____

How have you tried to alleviate this problems? _____

Have you consulted another Physician for this problem? Y _____ N _____ Give Name _____

What tests were done? _____ What was the diagnosis? _____

What prescription medication are now taking? _____

What supplements are you now taking? _____

Major Illnesses and dates _____ Any type of surgery and dates _____

_____ _____

_____ _____

Major car accidents, falls, injuries and dates _____ Major TMJ or dental work and dates _____

_____ _____

_____ _____

Hobbies and Sports _____

Family history, who had this?

Diabetes _____ Cancer _____ Breast Cancer _____ Stroke _____

Heart Disease _____ High Blood Pressure _____ Hypoglycemia _____

Osteoporosis _____ Rheumatoid or other Autoimmune Disorders _____

Women Only:

Have you missed any periods? Y _____ N _____ Any menstrual discomfort? Y _____ N _____

Recurrent yeast infections or vaginitis? Y _____ N _____ Are you on birth control pills? Y _____ N _____ Are you on HRT? Y _____ N _____

THIS CLINIC DOES NOT ACCEPT INSURANCE ASSIGNMENT OR WORKMAN'S COMP. I UNDERSTAND THAT ALL OFFICE VISITS ARE PAYABLE AT THE TIME OF APPOINTMENT, AND THAT APPOINTMENTS NOT CANCELLED WITHIN 12 HOURS PRIOR TO A MISSED VISIT WILL BE CHARGED FOR THE VISIT.

INFORMED CONSENT: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks or treatment. The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and headache. The scientific literature suggests that serious events such as stroke are rare and that chiropractic is safe.

AUTHORIZATION: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered to me or my dependents.

X Signature of Patient (or parent if a minor)_____ Date _____

FINANCIAL RESPONSIBILITY: Payment for services are due at the time services are rendered unless other arrangements have been approved in advance. Our fees normally fall within the UCR which is defined as the usual, customary, and reasonable charges for this region. This office has no contract with any insurance agency, only with you, the patient. You may submit your receipt to your insurance provider for reimbursement if you are eligible. Not all insurance providers will pay for services performed at this office as it is considered a non-participating provider. It is your responsibility to determine if you are eligible for reimbursement.

I fully understand this agreement between this office and myself. I am ultimately responsible for the balance of my account for any professional services rendered.

X Signature of Patient (or parent if a minor)_____ Date _____