Dr. Stacey Francis
Chiropractic Kinesiologist
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Specific Wellness clinics

Date _____ Medicare (yes or no) _____
Name _____ Age _____ Birthdate _____ M _____ F____
Home Address _____ City _____ State _____ Zip _____
Phone (home) _____ (work) _____ (cell) _____
Email Address _____
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 problem _____
Have you consulted another Physician for this problem? Y ____ N ____ Give Name _____
What tests were done? _____ What was the diagnosis? _____
What prescription medication are you 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 CANCELED WITHIN 12 HOURS PRIOR TO A MISSED VISIT WILL BE CHARGED FOR THE VISIT.

Please Initial _____

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.

Please Initial _____

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 ____/____/____