# DAVIS CHIROPRACTIC NEW PATIENT FORMS

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

DOB: _____ Age: _____ Patient Sex: ____ Male ____ Female

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ How did you hear about us: _____

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Current Complaint:
Please list your **worst** complaint: _____
When did it start? _____ How did it start? _____
What makes it better? _____
What makes it worse? _____
Is the pain localized or does it radiate? If so, where? _____
Is the pain: ___ Improving ___ Worsening ___ Staying the Same
Do you notice it more in the: ___ Morning ___ Afternoon ___Night

Please use the chart below to rate the following questions.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No symptoms | Slight Discomfort | Does Not Affect Activity | Affects Personal Activities | Prevents Personal Activities | Limits My Work Schedule | Prevents All Working Activity | Prevents All Activity | Keeps Me Bedridden | Causes Thoughts of Suicide |

Please Circle:
Mark the severity of your complaint as it is **right now**.
1 2 3 4 5 6 7 8 9 10

Mark the severity of your complaint as it is on **average**.
1 2 3 4 5 6 7 8 9 10

Mark the severity of your complaint as it is **at its worst**.
1 2 3 4 5 6 7 8 9 10

Please list your **second worst** complaint: _____
When did it start? _____ How did it start? _____
What makes it better? _____
What makes it worse? _____
Is the pain localized or does it radiate? If so, where? _____
Is the pain: ___ Improving ___ Worsening ___ Staying the Same
Do you notice it more in the: ___ Morning ___ Afternoon ___ Night

Please Circle:
Mark the severity of your second complaint as it is **right now**.
1 2 3 4 5 6 7 8 9 10

Mark the severity of your second complaint as it is on **average**.
1 2 3 4 5 6 7 8 9 10
9

Mark the severity of your second complaint as it is **at its worst**.
1 2 3 4 5 6 7 8 9 10

Please mark if you have a history of any of the following:

- Musculoskeletal

___ Back pain ___ Headaches ___Extremity Pain ___Bone Demineralization
___Unstable Fractures ___ Spinal Infection ___Spinal Tumors

- Neurological

___Sudden Numbness ___Sudden Headache ___Loss of Sensation ___Confusion
___Dizziness ___Slurred Speech ___Loss of Balance

- Cardiovascular

___High Blood Pressure ___Heart Disease ___Arterial Aneurysm ___Angina
___Irregular Heart Beat ___Bleeding Disorder ___Heart Attack

- Other

___Stroke ___Diabetes ___ Cancer ___Fever ___Vertigo ___Loss of Bowel Control
___Fatigue ___Common Cold ___Abdominal Pain ___Loss of Bladder Control

List all prescription medications you are currently taking.

List all over the counter medications you are currently taking.

List all of the surgical procedures that you have had.

List all of the times you have been hospitalized.

List all significant past traumas that you have had.

Does anyone in your immediate family have a history of any of the following?

___Heart Disease ___Stroke ___Diabetes ___Cancer

If so, who? _____

Provide any other information important for us to know.