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: _____________________

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 travel? 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 travel? 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

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.

Davis Chiropractic Consent Forms Name: ____________________

Date:

Please read the complete form and sign the bottom.

At Davis Chiropractic, we do not cure diseases, illnesses, or other diagnoses. However, regular chiropractic care can greatly benefit you and your body. We simply find spinal subluxations, restrictions, and misalignments, correct them by adjusting the body, and we let the body do the rest as the body is a self-healing organism. We offer non-therapeutic care. We do not diagnose or treat any conditions or symptoms.

I acknowledge that I give consent and authorize the doctor at Davis Chiropractic to perform evaluation and management procedures for the purpose of performing an examination and delivering treatment. If, during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. If symptoms ever begin to make you feel suicidal, please seek help at an urgent care facility.

The patient examination process includes important tests that require movement, exertion, and balance control and may result in worsening of symptoms, muscle strain, and falling. I accept these risks and agree that I will provide correct answers and information and I will notify Davis Chiropractic if there has been a change in any of my answers and information.

We, at Davis Chiropractic, cannot share your personal or medical information with any outside party without your approval. By signing below, I authorize Davis Chiropractic to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, communicating with my referring physician (if applicable), and any other administrative operations related to treatment or payment.

I agree to receive calls, texts, emails, and messages from Davis Chiropractic to schedule/reschedule appointments, collect payment, and discuss health related information with Dr. Davis.

I understand Davis Chiropractic does not make any assurances or guarantees. They do not offer anything other than a subluxation diagnosis, or treat any symptoms. They can terminate membership at their discretion. They offer no refunds or reimbursement should I cancel any agreement.

Davis Chiropractic does not accept any insurance. I understand that I am responsible for all charges, and understand payment is due at the time of service.

All memberships are based on a 48-week calendar allowing for personal time away from the office. Barring extenuating circumstances, additional days/weeks will not be added to memberships for holidays or personal time away from the office.

If you have read the consent form in its entirety and you understand & agree to the above statements, please sign below.

____

Print Name

____

Signature

____

Date

Davis Chiropractic Consent Forms Name: ____________________
Date:

Consent to evaluate and adjust a minor child:

I, ____________________________ being the parent or legal guardian of __________________________ have read and fully understand the Informed Consent and hereby grant permission for my child to receive chiropractic care.

____
Print Name

____
Signature

____
Date