

Davis Chiropractic New Patient Paperwork

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

Davis Chiropractic Name: _____ Date: _____

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

Davis Chiropractic Name: _____ Date: _____

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.

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.

Please mark if you are interested in any of the following therapies:

Muscle Taping Cupping Electrical Stimulation (TENS)

Please mark if you are interested in any of the following:

Quick Appointments (Get in, get adjusted, get out)

Treatment Plans (Recommended plan/visits to get you feeling & functioning better)

Pay-per-visit (Pay each visit rather than using packages/memberships)

Silent Appointments (No small talk)

Stretching Guides

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.

The risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and costovertebral strains/separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor. **The probability of those risks occurring:** Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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

Sign 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