Davis Chiropractic ▪ Pain & Headache Center ▪ Dr. Jason Davis

Confidential Patient Data

Office Use: Exam Date_____ Patient ID_____

Name: _____ DOB: _____ SS#_____-_____-_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Email Appointment Reminder? YES NO

Language: English Spanish _____ Race: White - African American – Hispanic - Other_____

Emergency Contact: _____ Phone: _____

Your Occupation: _____ Your Employer: _____

Referred to this Office by: ○ Friend/Family Member – Name? _____

○ Newspaper ○ Phone Book ○ Website ○ Doctor Other _____

Name of local primary care physician: _____City: _____

INSURANCE INFORMATION

Name of Insurance Co.: _____ ID#: _____

MEDICAL HISTORY Please indicate which conditions you have (or had) been diagnosed with:

☐AIDS	☐dislocated joints	☐neck pain	☐polio
☐anemia	☐epilepsy	☐nervousness	☐poor circulation
☐arthritis	☐German Measles	☐numbness	☐diabetes
☐asthma	☐headaches	☐polio	☐rheumatic fever
☐back pain	☐heart trouble	☐poor circulation	☐rheumatism
☐bladder trouble	☐reproductive disorders	☐hepatitis	☐scarlet fever
☐bone fracture	☐high blood pressure	☐muscular dystrophy	☐venereal disease
☐cancer	☐HIV/ARC	☐multiple sclerosis	☐sinus trouble
☐chest pain	☐kidney disorder	☐menstrual cramps	☐tuberculosis
☐concussion	☐bowel control loss	☐indigestion	

Mother History: ☐Cancer ☐Alzheimer's ☐Diabetes ☐Heart Disease ☐Hypertension ☐Kidney Disease ☐Osteoporosis ☐Stroke

Father History: ☐Cancer ☐Alzheimer's ☐Diabetes ☐Heart Disease ☐Hypertension ☐Kidney Disease ☐Osteoporosis ☐Stroke

Have you been treated for any health condition in the last year? Yes No

Describe condition_____ Date of last Physical exam? _____

SURGICAL HISTORY

1. _____ Date: _____ 2. _____ Date: _____

Have you ever had a metal implant? Yes No

ACCIDENT HISTORY Job Auto Other 1. _____ Date: _____

MEDICATION ALLERGIES - ☐ None _____

MEDICATIONS ☐ None

Medication Name	Dosage & Frequency

What supplements/vitamins do you take? _____ CPD

Patient Name: _____ Date: _____

What is your **PRIMARY LOCATION OF PAIN**? *WRITE ONLY ONE REGION IN BOX 1*

Common Problems Neck Pain Headaches Back Pain Shoulder Elbow Hand Hip Leg Knee Foot

1. _____

WRITE ONLY ONE REGION ON THE LINE ABOVE

Please rate your pain on a scale of 1-10.

(1-minimal pain, 10 extreme pain) 1 2 3 4 5 6 7 8 9 10

DURATION: ☐past week ☐past month ☐1-2 months ☐3-6 Months ☐1 year ☐ >year Other _____

CAUSE: ☐Fall ☐Gradual ☐Lifting ☐Job Injury ☐Shoveling/Raking ☐Unknown Other _____

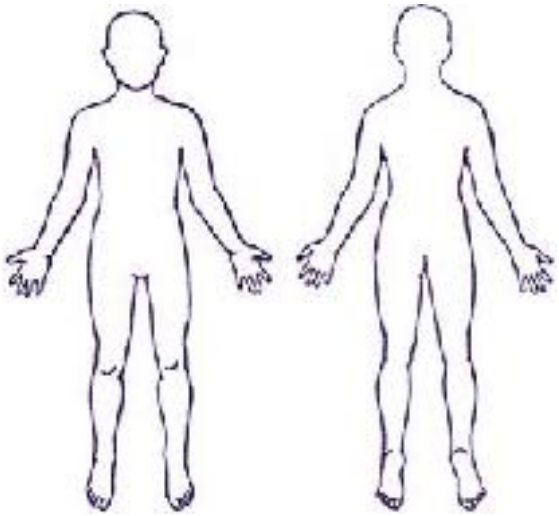
TYPE: ☐Aching ☐Cramping ☐Numbness ☐Sharp ☐Burning ☐Dull ☐Radiating Other _____

FREQUENCY: ☐Constant ☐Frequent ☐Intermittent ☐Occasional Other _____

AGGRAVATED BY: ☐Bending ☐Coughing ☐Exercising ☐Lifting ☐Lying Down ☐Moving Other _____

Mark on the body diagram where your pain/symptoms are present

Front Back



RELIEVED BY: ☐Exercise ☐Heat/Ice ☐Ibuprofen ☐Lying down ☐Medication ☐Sitting ☐Stretching Other _____

PRIOR INTERVENTIONS: ☐Acupuncture ☐Overcounter meds ☐Prescriptions ☐Massage ☐Surgery Other _____

Secondary Location 2._____ **Please rate your pain on a scale of 1-10. 1 2 3 4 5 6 7 8 9 10**

DURATION: ☐past week ☐past month ☐1-2 months ☐3-6 Months ☐1 year ☐ >year Other _____

CAUSE: ☐Fall ☐Gradual ☐Lifting ☐Job Injury ☐Shoveling/Raking ☐Unknown Other _____

TYPE: ☐Aching ☐Cramping ☐Numbness ☐Sharp ☐Burning ☐Dull ☐Radiating Other _____

FREQUENCY: ☐Constant ☐Frequent ☐Intermittent ☐Occasional Other _____

AGGRAVATED BY: ☐Bending ☐Coughing ☐Exercising ☐Lifting ☐Lying Down ☐Moving Other_____

RELIEVED BY: ☐Exercise ☐Heat/Ice ☐Ibuprofen ☐Lying down ☐Medication ☐Sitting ☐Stretching Other_____

PRIOR INTERVENTIONS: ☐Acupuncture ☐Overcounter meds ☐Prescriptions ☐Massage ☐Surgery Other_____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

Blurred vision ▪ buzzing in ears ▪ cold feet ▪ cold hands ▪ cold sweats ▪ concentration loss/confusion ▪ constipation ▪ depression/weeping spells ▪ diarrhea ▪ dizziness ▪ face flushed ▪ fainting ▪ fatigue ▪ fever ▪ head seems too heavy ▪ muscle jerking ▪ numbness in fingers ▪ numbness in toes ▪ pins and needles in arms ▪ pins and needles in legs ▪ ringing in ears ▪ shortness of breath ▪ stiff neck ▪ stomach upset ▪ urinating change/difficulty ▪

What kind of exercise do you do? _____ How often? _____

How much do you smoke per day? never quit _____ Drinks per week? never quit _____

Women ONLY – How many children? _____ Are you pregnant? Yes No Are you on birth control pills? Yes No

Davis Chiropractic

Jason E. Davis, D. C.

Today's Date: _____/_____/_____

HIPAA PRIVACY

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that if I would like to have any restrictions applied to my records I can provide those in writing at any time to the HIPAA Privacy Officer, Michelle Davis.

Please sign below for HIPAA Privacy:

Patients Name (or Legal Guardian): _____ (please print) Date of Birth: _____

Signature: _____

PATIENT CONSENT/FINANCIAL POLICY

All questions completed on Davis Chiropractic's intake forms are complete and accurate, and I understand that giving incorrect information can be dangerous.

I understand Davis Chiropractic does not diagnose or treat any disease but only neuro-musculoskeletal conditions. I have read and fully understand the above statements. All questions regarding the Doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible foe any outstanding amount owed this office.

I agree to pay Davis Chiropractic for any and all patient balances within 30 days of being billed unless a separate payment arrangement is made.

Please sign below for Patient Consent:

Patients Name (or Legal Guardian): _____ (please print) Date of Birth: _____

Signature: _____