APPLICATION FOR CARE at Davis Chiropractic

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: ____-____-____ Age: _____ O Male O Female

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Marital Status: O Single O Married O Divorced O Widow

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Number of children and ages: _____

Emergency Contact Name: _____ Phone_____ Relationship: _____

Do you have insurance? O Yes O No If yes Insurance Name:_____

* If covered by parent/spouse/other: Name:_____ Birthdate: _____

HISTORY OF COMPLAINT

Is this related to an accident? ❑Yes ❑No If yes ❑Work ❑Slip & Fall ❑Car ❑Sports/Personal

Describe:_____

Please identify the condition(s) that brought you to this office: 1): _____

2: _____ 3: _____ 4: _____

On a scale of **0 -10** with **10** being the WORST PAIN & **0** being NO PAIN, rate your above complaints by ***circling the number*:**

1st complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2nd complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3rd complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
4th complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? O AM O PM O Night

How long does it last? O Constant O On & off during the day O Comes & goes throughout the week

Have Condition(s) been treated by anyone in the past? O No O Yes **If yes,** Date:? _____ by who? _____

How long were you under care? _____ What were the results? _____

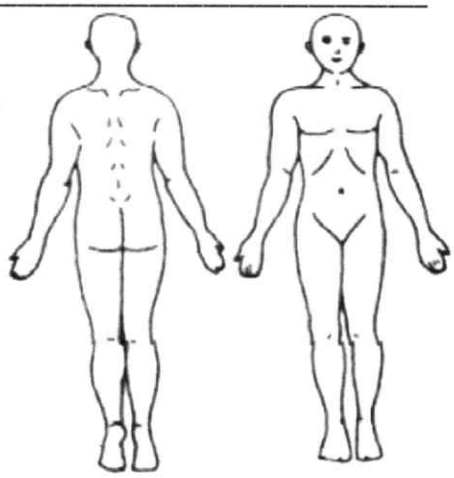
Name of previous chiropractors: _____ ❑N/A

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

PLEASE CIRCLE the body where you feel pain/discomfort:

R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umb **S = S**harp/**S**tabbing **T = T**ingling



PATIENT'S NAME: _____ HR#: _____ DATE: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? O No O Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen? _____

_____

Other forms of treatment tried: O No O Yes **If yes,** please state what type of treatment: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Have you had the COVID-19 infection? O No O Yes **If yes,** how many times? _____

Have you been diagnosed with Long term COVID-19 effects? O No O Yes

If you have ever been diagnosed with any of the following conditions, please indicate with:

Check off if you had any of the following conditions:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

***PLEASE IDENTIFY ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:*

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? O No O Yes **If yes,** whom?
   O grandmother O grandfather O mother O father O sister(s) O brother(s) O son(s) O daughter(s)
2. Any other hereditary conditions the doctor should be aware of? O No O Yes: _____

SOCIAL HISTORY

1. Smoking: O cigars O pipe O cigarettes How often? O Daily O Weekends O Occasionally O Never
2. Alcoholic Beverage: consumption occurs O Daily O Weekends O Occasionally O Never
3. Recreational Drug use: O Daily O Weekends O Occasionally O Never

I hereby authorize payment to be made directly to Davis Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Davis Chiropractic for any and all services I receive at this office.

_____
Patient or Authorized Person's Signature

_____ - _____ - _____
Date Completed

_____
Doctor's Signature

_____ - _____ - _____
Date Form Reviewed

Name:_____ Date:_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carry Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ **Today's Date:** __/__/__

Continued on next page

Name:_____ Date:_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 worst possible pain

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

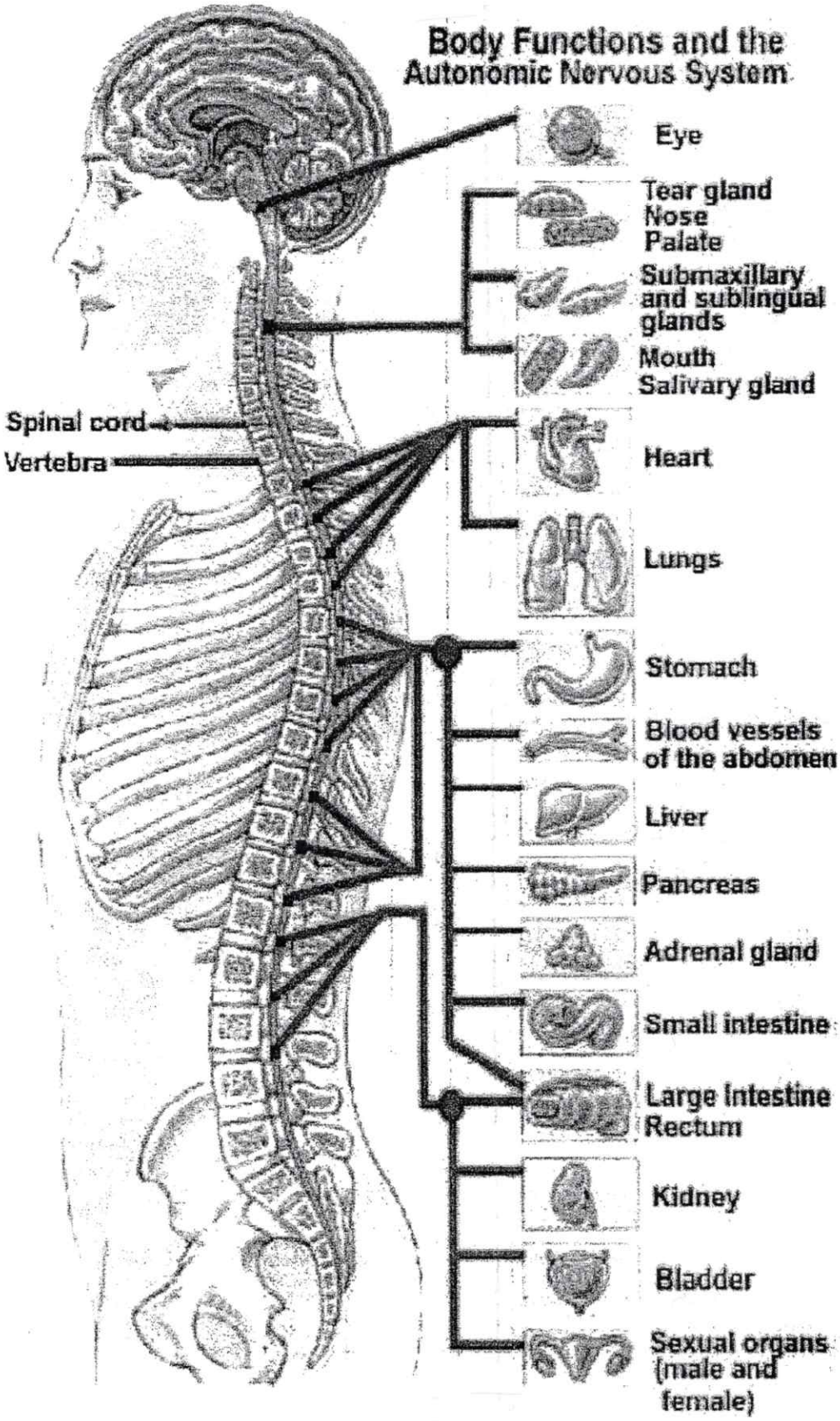
_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Name: _____ Date: _____



- ☐ Neck Pain
- ☐ Headaches & Migraines
- ☐ Pain behind Eyes or Blurriness
- ☐ Shoulder Pain or Weakness
- ☐ Arm/hand Pain or Numbness
- ☐ Cold Hands or Feet
- ☐ High Blood Pressure
- ☐ Nervous Breakdowns
- ☐ Tiredness
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Sinus Pressure / Allergies
- ☐ Ringing/Buzzing Ears
- ☐ Sore Throat / Throat Infections
- ☐ Insomnia
- ☐ Loss of Memory
- ☐ Inability to Concentrate
- ☐ Mid Back Pain
- ☐ Rib
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Asthma
- ☐ Upper Respiratory Problems or Bronchitis
- ☐ Constipation / Diarrhea
- ☐ Excessive Gas / Bloating
- ☐ Stomach/Abdominal Pain or Cramps
- ☐ Indigestion / Heart Burn /Acid Reflux
- ☐ Excessive Menstrual Cramping
- ☐ Low Back/Pelvic/Hip Pain
- ☐ Sciatica
- ☐ Leg/Knee/Foot Pain
- ☐ Leg/Knee/Feet Weakness/Cramps or Swelling
- ☐ Poor Leg Circulation
- ☐ Hernias
- ☐ Excessive or Frequent Urination
- ☐ Prostrate Problems
- ☐ Urinary Infections
- ☐ Impotence / Infertility
- ☐ Pain at the end of the spine on sitting
- ☐ Buttocks Pain or Numbness
- ☐ Problems with Rectums
- ☐ Hemorrhoids
- ☐ Spinal Curvatures