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:V	Vork Phone:	Mobile Phone:	
Marital Status: O Single O Married O D	ivorced O Widow		
Social Security #:	Driver's License #:		
Employer:	Occupation:		
Number of children and ages:			
Emergency Contact Name:	Phone	Relations	hip:
Do you have insurance? O Yes O No If yes Ins	surance Name:		
* If covered by parent/spouse/other: Name:		Birthdate:	
	HISTORY OF COMPLAINT		
Is this related to an accident? □Yes □	No If yes Work US1	ip & Fall □Car □S	ports/Personal
Describe:		•	
Please identify the condition(s) that brought you to			
2:			
On a scale of 0 - 10 with 10 being the WORST	PAIN & 0 being NO PAIN, rate yo	our above complaints by <i>cir</i>	cling the number:
	4 - 5 - 6 - 7 - 8 - 9 - 10 4 - 5 - 6 - 7 - 8 - 9 - 10 4 - 5 - 6 - 7 - 8 - 9 - 10		
When did the problem(s) begin?	When is the problem	at its worst? O AM O PN	И O Night
How long does it last? O Constant O On &	off during the day O Comes & go	es throughout the week	
Have Condition(s) been treated by anyone in the p	ast? 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?		——— Jana	
PLEASE CIRCLE the body where you feel page R = Radiating B = Burning D = Dull A = Achin		= Tingling	

PATIENT'S NAME:			HR#	:	DATE:
		PAST H	STORY		
		r problem in the past? O N the injury happen?			
Other forms of treatme	nt tried: O No O Ye	s If yes, please state what	type of treatment: _		
Please identify any and	all types of jobs you h	nave had in the past that ha	ave imposed any phy	sical stress on you or	your body:
Have you had the COVII	D-19 infection? O No	O Yes If yes, how many	y times?		
Have you been diagnos	ed with Long term CC	IVID-19 effects? O No O	Yes		
If you have ever been d	iagnosed with any of	the following conditions, p	lease indicate with:		
	91	Check off if you had any of	the following condi	tions:	
		Tumors Rheuma Diabetes Cerebral			
PLEASE IDENTIFY ALL P		T conditions you feel may l	be contributing to yo		
INIUIDIES	HOW LONG AGO	TYPE OF CARE		PROVID	ED BY WHOM
INJURIES					
CHILDHOOD DISEASES					
ADULT DISEASES					r.
		FAMILY	HISTORY		
O grandm	other O grandfath	e same condition(s)? O No er O mother O father r should be aware of? O I	O Yes If yes, who O sister(s) O br		O daughter(s)
		SOCIAL I	HISTORY		
 Smoking: O cigars Alcoholic Beverage: 3. Recreational Drug us 	consumption occurs	How often? O Daily O Daily O Daily	O Weekends O Weekends O Weekends	O Occasionally O Occasionally O Occasionally	O Never O Never O Never
other collateral sources.	l authorize utilization of the this assignment of be	enefits does not in any way r	thereof, for the purpo	se of processing clain	ealthcare plan or from any ns and effecting payments, and I remain financially responsible
Patient or Authorized	d Person's Signatur	e	Date Comp	leted	
Doctor's Signature			 Date Form	 Reviewed	

ACTIVITIES:		CCT:		
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
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 Perfor
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perfor
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perfor
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perfor
Garbage	□ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perfor
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perfor
www.anti-fileticted	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perfor

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Name	:										_ Da	ate:
										QUADRU	JPLE VI	SUAL ANALOGUE SCALE
Please r	ead ca	refully:										
Instruct	ions: F	lease circ	cle the num	ber that b	est descri	bes the que	estion bei	ig asked.				
Note:	If you	have mo laint. Ple	ore than one	e complais e your pas	nt, please in level ri	answer ead ght now, av	ch questio verage par	n for each	individua in at its bes	complair and wor	nt and in	dicate the score for each
Example	e:											
		1	Headache			Neck			Low Back			
No pain	0	1	(2)	3	4	(5)	6	7	8	9	10	worst possible pain
	1 - V	Vhat is yo	our pain R	IGHT NO	DW?							
No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
	2 – W	hat is yo	our TYPIC	AL or A	ERAGE	pain?				3.		
No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
	3 – W	lat is yo	ur pain le	vel AT IT	S BEST	(Haw class	e ta "0" d	oes vour	pain get a	t its best)'	?	
No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
	4 – W	hat is yo	ur pain le	vel AT IT	's WORS	ST (How cl	lose to "l	0" does y	our pain g	et at its w	vorst)?	
No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
OTHER	сом	MENTS:										

Ringing/Buzzing Ears Stormach Insommia Lungs Inability to Concentrate Mid Back Pain Rib Chest Pain Heart Palpitations Asthma Upper Respiratory Problems or Bronchitis of the abdomen Excessive Gas / Bloating Liver Stomach/Abdominal Pain or Cramps Indigestion / Heart Burn /Acid Reflux Excessive Menstrual Cramping Low Back/Pelvic/Hip Pain Sclatica Leg/Knee/Feet Weakness/Cramps or Swelling Poor Leg Circulation Hernias Excessive or Frequent Urination Prostrate Problems Chest 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 Spinal Curvatures Spinal Curvatures Pain Postrate Problems Problems with Rectums Hemorrhoids Spinal Curvatures Pain	The state of the s			
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Date: _

Name: _