

APPLICATION FOR CARE AT DAVIDSON FAMILY CHIROPRACTIC

Today's Date: _____ PtID: _____

PATIENT DEMOGRAPHICS

Legal Name: _____ Preferred Name: _____ Birth Date: ____/____/____ Age: _____
 Address: _____ City: _____ State: ____ Zip: _____
 Mobile Phone: _____ Home Phone: _____ Work Phone: _____
 E-mail Address: _____ Occupation: _____ Employer: _____
 Marital Status: **M S D W** Name of Spouse or Significant Other: _____ # of children: _____
 Health Insurance: Yes or No Name & Phone Number of Emergency Contact: _____

HISTORY of COMPLAINT

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

Chief complaint: _____

Secondary Complaint(s) or symptoms associated: _____

When did the problem(s) begin? _____ is your problem the result of ANY type of accident. Yes No

If yes identify type: Auto Work Home Other (please explain): _____

Date of Accident: _____ - _____ - _____ approximately what time of day? ____am ____pm

Have you reported this accident to anyone? No Yes if yes to whom: _____

Have you suffered with any of this or a similar problem in the past? No Yes If yes, when? _____

Other forms of treatment tried? _____, and who provided it: _____
 _____ When? _____

What were the results? Favorable Unfavorable → please explain. _____

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness
S = Sharp/ Stabbing T = Tingling

When is the problem at its worst? Morning Mid-day Evening Night

How long does it last? It is constant I experience it intermittently

What relieves your symptom(s) _____

What makes them feel worse? _____

Have you been to a Chiropractor before? Yes or No

Last visit? _____ When was your last spinal exam, including x-rays? _____

Were the visits primarily for pain management? Yes or No

On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain:

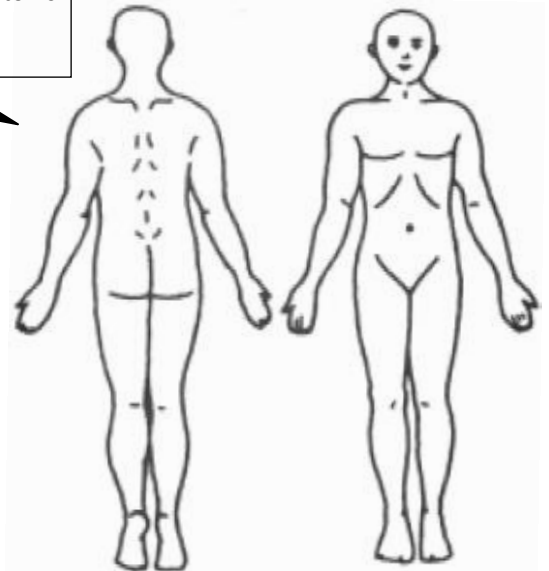
Rate how you feel today (**Circle the number**):

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have or

Leave blank for **Never** have had: _____ Broken Bone/Fracture _____ Dislocations _____ Disability _____ AIDS/HIV
 _____ Rheumatoid Arthritis _____ Hepatitis (A,B,C) _____ Tumor(s) _____ Cancer _____ Diabetes
 _____ Cerebral Vascular/Stroke _____ Heart Attack _____ Other serious condition(s): _____

Please mark: **C** for **Currently** have, **P** for the **Past** or **Leave Blank** for **Never** have had

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Heartburn/Indigestion |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Irritable/Moody | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Asthma/Breathing Issues |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Bladder Problem | |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | <input type="checkbox"/> Weight Issues | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Liver /Gallbladder Problems | |

ACTIVITIES of DAILY LIVING

1. Indicate which of the following daily tasks are affected: Bending Carrying Climbing Concentrating Dancing
 Doing Chores Doing Computer Work Dressing Driving Gardening Lifting Performing Sexual Activity
 Playing Sports Pushing Reading Recreating Rolling Over Running Shoveling Sitting
 Sitting to Standing Sleeping Standing Walking Watching TV Working
2. Indicate Pain during Daily Tasks: No Pain (0) Very Mild Pain (1) Mild Pain (2) Very Tolerable Pain (3)
 Tolerable Pain (4) Somewhat Moderate Pain (5) Moderate Pain (6) Moderate-Severe Pain (7) Severe Pain (8)
 Very Severe Pain (9) Disabling Pain (10)

SOCIAL HISTORY

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

4. Over-the-counter & Prescription Medication use:

- | | | | |
|-------------------|---|------------------------------|---|
| Anti-Depressants: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never | NSAIDS (Aspirin, Ibuprofen): | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |
| Muscle Relaxers: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never | Stimulants: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |
| Blood Pressure: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never | Pain Killers: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |
| Heart Meds: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never | Blood Thinners: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |
| Mood Stabilizers: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never | Cholesterol Meds: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |
| Insulin: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never | Hormone Meds (Estrogen): | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |
| Other Meds: _____ | | Acid Reflux/Heartburn Meds: | <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never |

How many Medications are you currently taking: _____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s) you currently have? No Yes If yes whom:

grandmother grandfather mother father sister's brother's son(s) daughter(s)

Have they ever been treated for their condition? No Yes I don't know

2. Any other hereditary conditions the doctor should be aware of? No Yes: _____

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I hereby authorize payment to be made directly to Davidson Family 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 Davidson Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

_____/_____/_____
Date Completed

Reserved for doctor's use only Systems reviewed with patient:

- Musculoskeletal Neurological