



New Patient Intake Form

Date _____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Nickname/Preferred name: _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Please circle preferred method of contact below:

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Cell Phone (____) _____ - _____ **Email** _____

Date of Birth ____/____/____ **Sex:** Male Female

Social Security Number: ____ - ____ - ____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other _____

Spouse Data

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

Doctor's Signature _____

Patient Name _____ **Date** _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | | |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Urogenital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Other _____ | | | |

Allergies: (Check all that apply to you)

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: (Check all that apply to you)

- | | | | |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Chew Tobacco: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional | <input type="checkbox"/> always | <input type="checkbox"/> never |
| Other _____ | | | |

Family History: (Check all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____ | | |

For Office Use Only	
BP-	_____
P-	_____
R-	_____
Wt. -	_____
Ht. -	_____
Foot Scan	_____

Occupational Activities: (Check one that best describes your job description)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Other _____ | | | |

Doctor's Signature _____

Patient Name _____ **Date** _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	Respiratory			No	Allergic/Immunologic			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

Doctor's Signature _____

Patient Name _____

Date _____

How are your symptoms changing?

- Getting better Not changing Getting worse

Employment, ADL, and Recreation Information

Description of Work: _____

- Condition's Effect On Job Performance:** **No Effect** **Mild** (painful can do) **Mod** (painful limited ability)
 Mod/Sev (limited duty) **Sev** (no limited duty) **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- | | | | | |
|--------------------------|---|---|---|---|
| Bending: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Care –Infirm Family: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Carrying Groceries: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Change Posn–Sit–Stand: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Climb Stairs: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Driving: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Extended Computer Use: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Feeding: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Household Chores: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Kneeling: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lift Children: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lifting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Pet Care: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Reading (Concentration): | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Bathing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Dressing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Shaving: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sexual Activities: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sleep: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Sitting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Standing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Walking: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Yard Work: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |

Recreational Activity: Effects of Current Condition on Performance

- | | | | | |
|-------|---|---|---|---|
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |

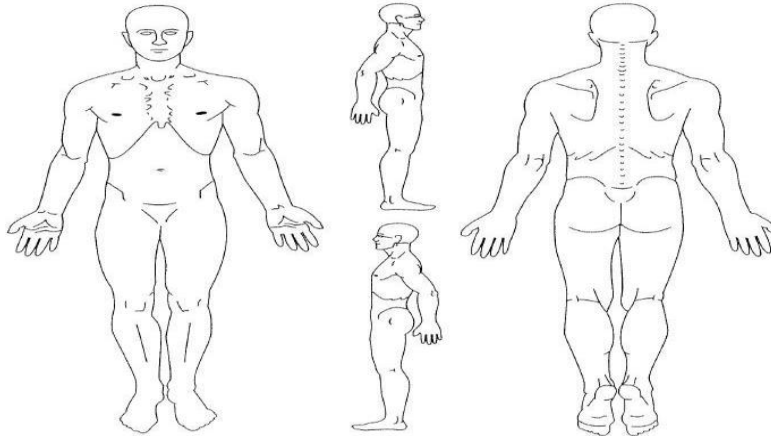
Doctor's Signature _____

Patient Name _____ **Date** _____

Are you pregnant? Yes _____ No _____ N/A _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worst symptom being

#1: _____ Date it began: _____

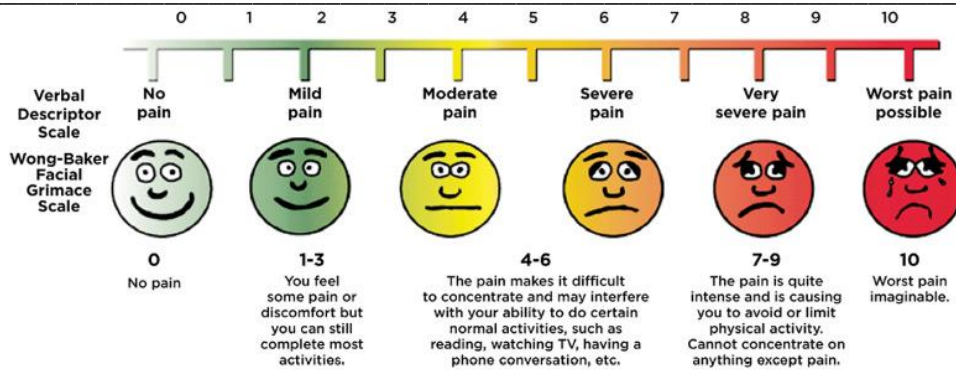
#2: _____ Date it began: _____

#3: _____ Date it began: _____

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____



How often do you experience your symptoms?

- Constantly (76-100% of the day)
 Frequently (51-75% of the day)
 Occasionally (26-50% of the day)
 Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp Dull ache Numb Shooting
 Burning Tingling Stabbing Other _____

Doctor's Signature _____



Patient Name _____ **Date** _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
 Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth ____ / ____ / ____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____ / ____ / ____ Time: ____ am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date _____

SIGNATURE OF PHYSICIAN: _____ **Date:** _____



DAVIS CHIROPRACTIC SPECIALISTS : INFORMED CONSENT

Terms of Acceptance:

When a person seeks chiropractic health care and when a chiropractic physician accepts that person for care, it is essential that both parties are informed and working for the same goals.

Clarifications:

Adjustment: An adjustment is the specific application of forces to aid the body’s healing of the spine. Our chiropractic method of correction is by specific adjustment of the spine.

Spinal Subluxation: A misalignment of one or more of the 24 vertebra, pelvis (hips), sacrum (tailbone) or cranium (skull) in the spinal column which causes alteration of proper biologic and biomechanical function, including the nerve, blood, muscle and connective tissue functions, reducing of the body’s ability to function normally or optimally.

Objectives:

With a proper function, health improves. In some, symptoms clear up quickly. For others, the process is slower. I do not offer to diagnose or treat any pathologic or organic diseases (ex. cancer). *OUR PRIMARY OBJECTIVE* is to allow your body (ie. the spine) to attain optimal function. This goal is accomplished with specific adjustments and ancillary treatment to correct spinal subluxation complexes. The chiropractic evaluation and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of chiropractic care.

Ancillary Treatment – Most of the other treatments performed in this office have little or no significant risk associated with them. If a treatment is used that has a measure of risk involved, you will be notified at that time of that risk

The availability and nature of other treatment options – Other treatment options for your condition include: self-administered over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization with traction; and surgery.

The material risks inherent in such options and the probability of such risks occurring include – Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines. Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks-some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to a communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely and with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The material risks inherent in chiropractic adjustment – As with any health care procedure, there are certain complications which rarely arise during a chiropractic adjustment. Those complications include: fracture, disc injuries, dislocations, muscle strain, Horner’s Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Rare 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 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 has been the subject of tremendous disagreement within and without the profession with prominent authorities saying that there is a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally rare.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED – Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

CONSENT TO CARE

I, _____ have read and fully understand the above statements.

All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I do hereby authorize the doctor of Davis Chiropractic Specialists to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure, which is advisable, and necessary for my health care.

I therefore accept chiropractic care on this basis. **Do not sign until you have read and understand the above statements**

(Signature) _____
(signature of parent or guardian if a minor)

(Date) _____



Pay to Patient Agreement

I, the undersigned (hereinafter “the Insured”) acknowledge service(s) received from Davis Chiropractic Specialists (hereinafter “DCS”). A service is defined as Chiropractic care, physiotherapies and/or massage therapy.

I further acknowledge my Insurance Carrier may send, directly to me, monies meant for reimbursement to DCS for services provided.

In the event I receive this reimbursement, I agree to endorse and forward payment to Davis Chiropractic Specialists within five (5) business days of receipt.

I am aware that Davis Spine Associate’s policy is to pursue collection to the fullest extent for any reimbursement made for their service(s) and not forwarded for payment by the Insured.

Patient (or Insured)

Date

Print Name



I _____, give permission to release any information in my medical file at Davis Chiropractic Specialists to the following people.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Signature: _____

Date: _____



APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your health care to Davis Chiropractic Specialists . We strive to render excellent care to you, your family, and all of our patients. In order to be consistent with this philosophy, we use an appointment system that sets aside ample time for a patient dependent on the patient’s current needs. If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit usually cannot be used to treat another patient and is time lost to our office.. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 704-664-6932.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice we will consider this to be a missed appointment and a fee (\$45.00 for massage/ \$25 for chiro only) may be assessed to you.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
4. **As a courtesy**, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact our office we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy and agree to be bound by its terms.

Signature (Parent / Legal Guardian)

Relationship to Patient

Printed Name

Date