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 ____

Davis
chiropractic Specialists

Patient Name____ **Date**__________________

How did you hear about our office? ____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _______________			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastrointestinal	☐ Urogenital	☐ Hernia
☐ Other _______________			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other __________

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never
Other _________________			

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling
Other __________________		

For Office Use Only

BP- __________________
P- __________________
R- __________________
Wt. - __________________
Ht. - __________________
Foot Scan _______________

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

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper
☐ Other _________________			

Doctor's Signature ____

Davis
chiropractic Specialists

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 ____

Davis
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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

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

Recreational Activity: Effects of Current Condition on Performance

Activity				
______________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
______________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
______________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

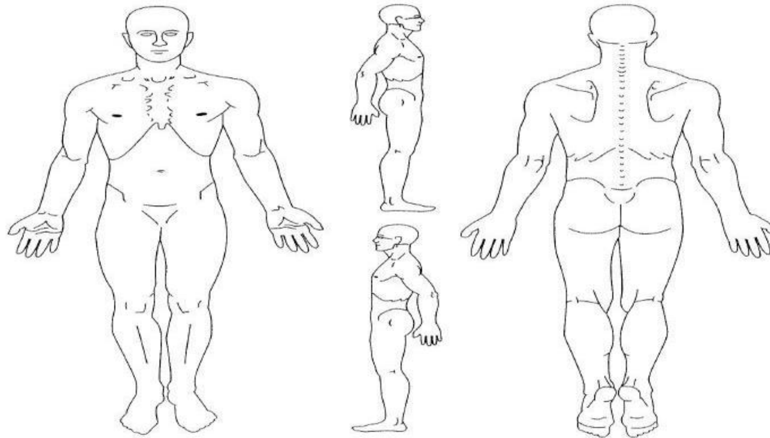
Doctor's Signature ______________________________

Davis
chiropractic Specialists

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



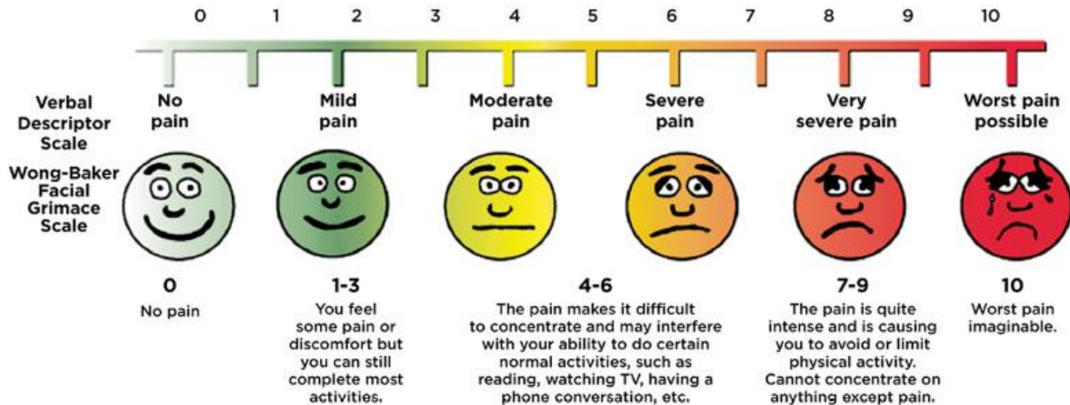
Describe your two worst areas of symptoms in order of severity, with worse symptom being first

#1: ____ Date it began: _______________________

#2:____Date it began: _______________________

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 ____

Davis
chiropractic Specialists

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)____________________________________ (Date)__________________________

(signature of parent or guardian if a minor)

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

Davis
chiropractic Specialists

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