# Dr. Davis Chiropractic

## Patient Intake Information

**Today's Date** For office use **Signature of Patient** _____

**Patient Title:** *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

**First Name**_____**MI**____**Nick Name**_____**Last Name**_____**Suffix**_____

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

**Primary Phone:**_____**Work Phone:** _____**Mobile Phone**_____

**Home Email:** _____ **Work Email** _____

**(By providing my email address, I authorize my doctor to contact me via the email address(es) provided.)**

**Which email address would you like us to use to communicate with you?** *(check one)* ❑ Home ❑ Work

**Contact Method** *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

**Date of Birth** / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

**Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

**Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**Race** *(check one)*

❑ White ❑ Black/African America ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian❑ I choose not to specify

**Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

**Preferred Language** *(check one)*

❑ English ❑ Spanish ❑ Indian ❑ Chinese ❑ French ❑ German ❑ Russian ❑ Italian Other_____

**How where you referred to our office?**_____**Where have you had Chiropractic Care?**_____

**List your chief complaints in order of severity, and for how long:**

**1.**_____

**2.**_____

**3.**_____

**List other doctors and address consulted for these conditions:**

**1.**_____

**2.**_____

**Is this injury or illness work-related?**___**Have you reported it to your employer?**_____

**Is this injury or illness related to an automobile accident?**_____**(If Yes name of )**

**Auto Inusurance Co.**_____**Policy#**_____**Claim#**_____

**Address**_____**Agents Name**_____

**Method of Payment you plan to use to take care of today's charges:**

**Check**_____**Cash**_____**MasterCard**_____**Visa**_____**Other**_____

**Do you have any type of major medical insurance?Yes_____No_____Company?_____**

**Address to mail claims_____Policy#_____Group#_____**

**Are you covered under any other group or individual health care policy through yourself or Spouse?_____**

**Insurance Company_____Address_____SpouseSS#_____**

**Employer_____Address_____**

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

***If yes, how often do you smoke:*** ❑ Current every day smoker ❑ Current sometimes smoker

***If yes, what is your level of interest in quitting smoking?***

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

*No interest* *Very Interested*

Vitals **To be performed by clinic staff:**

**Height:** _____inches **Weight:** _____ pounds **BP:** _____ / _____

**List Current medications:**

**If there are no current medications, check here: ❑**

| **Medication:** | **Dosage:** | **Frequency:** |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |

**List Medication Allergies:**

**If no allergies are known, check here: ❑**

| **Medication Allergy:** | **Reaction:** | **Date Began:** |
|---|---|---|
| **1.** | | |

**Briefly list your main health problems: Neck Pain_____Low Back Pain_____**

**Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No If yes, what : _____

_____

**Has any doctor diagnosed you with Diabetes presently?**❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

***If yes to Diabetes, was your blood lab-work test for hemoglobin A1C > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure

***May we obtain a copy of your A1C?*** ❑ **Yes** ❑ **No** ***List managing doctor:*** _____

**Have you had an X-ray or CT scan or MRI of your spine in the past 28 days?** ❑ Yes ❑ No

****Please note ** Request for release of records/ x-rays require 24 hour notice. Patient is responsible for all charges incurred that your insurance/personal injury case/ workers comp doesn't cover._____Patient Initial**