Case History

Name_____ Date_____
Address_____ State_____ Zip_____
H. Phone (_____)_____ W. Phone_____ Date of Birth_____ Age_____
Email address_____
Referred by_____Social Security #_____
Occupation_____ Employer_____
Marital Status S M D W Spouse Name_____
Number of Children/Ages_____ Spouses Occupation_____
Family Medical Doctor:_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

1.Current Health Habits:

Did/do you smoke?	Y	N	_____	_____
Did/do you drink alcohol?	Y	N	_____	_____
Diet, do you eat healthy foods?	Y	N	_____	_____
Have you been in accidents/trauma?	Y	N	_____	_____
Have you had surgery and organs removed/replaced?	Y	N	_____	_____
Drugs, including Prescription?	Y	N	_____	_____
Hearing problems?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/Mental stress?	Y	N	_____	_____
Hobbies/Sports injuries?	Y	N	_____	_____
Sleeping posture? O side O stomach O back			_____	_____

Symptoms and Present State of Health

Major Complaint_____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____

Please mark any of the following that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____

Is there a family History or current case of:

	Heart Disease	Head Aches	Cancer	Diabetes	Neck/Low Back Pain
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O
Spouse	O	O	O	O	O
Children	O	O	O	O	O

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Maintenance Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your needs and goal!

Consent to Treatment

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian
Signature_____Date_____

Acknowledgement of Privacy Practices

Davis Chiropractic follows the HIPAA Privacy Act. You have a right to a copy of Notice of Privacy Practices. By signing below I acknowledge that I have read, or declined to read and that I understand HIPPA and that these privacy practices will be followed by Davis Chiropractic to ensure the privacy of my personal health information.

Patient or Guardian
Signature_____Date_____

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services reflected by my insurance company.

Patient or Guardian Signature_____Date_____