

# Initial patient interview

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

1. What is the principal complaint for which you are seeking my care?

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2. List in order in severity (most severe first) any and **ALL** health problems which bother you. \_\_\_\_\_

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3. List any chronic health problems you used to have but which appear to be resolved. \_\_\_\_\_

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And any present problems which you have simply accepted as part of life, due to the fact that you can't see any way they'll leave. \_\_\_\_\_

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4. Other doctors seen for above conditions MD  DC  Lic. Ac.  DO   
DDS  Other \_\_\_\_\_ Name(s) of Doctor(s)

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5. List any accidents or injuries you have had, and approximately when they occurred. \_\_\_\_\_

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6. List any surgeries you have had ( including in-office procedures) giving dates where possible. \_\_\_\_\_

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7. List any prescription medications or over-the-counter (OTC) drugs you have taken for any length of time (eg. TUMS, Tylenol, Mylanta, etc.)

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8. List any prescription medications or OTC drugs you presently take.

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9. Do you take herbs? Y \_\_\_ N \_\_\_ , Vitamins Y \_\_\_ N \_\_\_  
Homeopathic medicines? Y \_\_\_ N \_\_\_

10. Do you feel you have menstrual or menopausal problems? Describe.

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11. Do you now or have you in the past taken birth control pills? Y \_\_\_ N \_\_\_

If so, when, and for how long? \_\_\_\_\_

12. How would you rate your own digestion (tolerance to foods, occurrence of what seem to be allergies to foods, etc.) \_\_\_\_\_

13. How would you describe your elimination, that is: Do you frequently experience loose stools or constipation? Y \_\_\_ N \_\_\_ If so, which, or both if they alternate. Do you have bowel movements daily? Y \_\_\_ N \_\_\_ .  
Approximately how many times? \_\_\_ If not daily, how often? \_\_\_\_\_

Please state any other relevant comments: \_\_\_\_\_

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14. In your own estimation, how do your kidneys and bladder function?

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15. Do you have weak or sensitive lungs? \_\_\_\_\_

16. Do you or members of your family have history of heart problems?

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**ENVIRONMENTAL/DIETARY EXPOSURE**

17. Do you drink primarily city water? Y\_\_ N\_\_  
bottled water? Y\_\_ N\_\_ Distilled \_\_ Spring \_\_\_\_
18. Do you live close to a freeway or other heavy traffic area? Y\_\_ N\_\_
19. Do you eat shell fish (shrimp, lobster, crab, scallops, etc.) regularly?  
Y\_\_ N\_\_ Which.
20. Do you use aluminum pans? Y\_\_ N\_\_ Did you ever? Y\_\_ N\_\_  
Do you use commercial body deodorants that contain aluminum? Y\_\_ N\_\_
21. How often do you eat : Chocolate \_\_\_\_\_, Ice Cream \_\_\_\_\_ ,  
Popcorn \_\_\_\_\_, Spicy foods \_\_\_\_\_, Pastries \_\_\_\_\_?
22. Do you drink carbonated “soft drinks” Y\_\_ N\_\_ How many per  
day?\_\_ week?\_\_ Regular\_\_ Artificially sweetened\_\_?
23. Do you smoke? Y\_\_ N\_\_ How much? \_\_\_\_\_
24. Do you drink coffee? Y\_\_ N\_\_ Cups per day? \_\_\_\_  
Tea Y\_\_ N\_\_ Cups per day? \_\_\_\_ Alcohol Y\_\_ N\_\_  
\_\_\_\_beers/week; \_\_\_\_ glasses of wine/week; \_\_\_\_ mixed drinks/week.
25. Are you exposed to or in contact with chemicals or fumes in your work  
environment? Y\_\_ N\_\_ Which ones?
26. Have you been exposed to new carpet, paint, particle board, or a new car  
recently? Y\_\_ N\_\_, please describe.
27. Please list on the average what you have for major meals and for snacks.  
Breakfast: \_\_\_\_\_  
\_\_\_\_\_  
Lunch: \_\_\_\_\_  
\_\_\_\_\_  
Dinner: \_\_\_\_\_  
\_\_\_\_\_  
Snacks: \_\_\_\_\_  
\_\_\_\_\_

28. Do you work on computers? \_\_\_\_\_

How often and for how long? \_\_\_\_\_

29. Please indicate whether you have regular exercise/sports/hobbies.

\_\_\_\_\_

30. Have you ever had chiropractic care before? Y \_\_\_ N \_\_\_ Did it seem to help you? Y \_\_\_ N \_\_\_ or to aggravate your condition? Y \_\_\_ N \_\_\_.

31. Have you ever had x-rays before? Y \_\_\_ N \_\_\_ How long ago, and for what? \_\_\_\_\_

\_\_\_\_\_

32. When is the last time you had lab work performed, and for what?

\_\_\_\_\_

\_\_\_\_\_

33. (CONFIDENTIAL- WILL NOT BE RELEASED WITH MEDICAL RECORDS) Have you ever used recreational drugs? Y \_\_\_ N \_\_\_ Which ones?

34. Do you have breast implants or prostheses? Y \_\_\_ N \_\_\_ Which \_\_\_\_\_

I hereby state that the information on both pages of this form is true and correct. I authorize Dr. Brent Davis to examine, perform diagnostic tests, and do what he deems necessary in his best clinical judgment and in accord with the state statutes, for the care and management of my condition. I also authorize release of medical records to legitimate parties requesting them.

I understand the health and accident insurance policies are an arrangement between and insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment, and that any amount authorized by my assignment to be paid to Dr. Davis will be credited to my account; and should any assigned payment be sent by the insurance company to me rather than to Dr Davis's office. I will immediately remit that payment in full to Dr. Davis's office. Furthermore, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. FEES FOR INITIAL VISIT MUST BE PAID ON DAY OF SERVICE.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's or Guardian's signature authorizing care  
(Sign only in the case of a minor)

\_\_\_\_\_  
Date