

Initial patient interview

Patient's Name _____

Date _____

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

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

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

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. _____

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

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

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

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

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

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.

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: _____

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

15. Do you have weak or sensitive lungs? _____

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

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