Davis Chiropractic
100 South Diamond St.
Mercer, Pa 16137
www.mercerdavischiro.com

Dr. Richard E. Davis, D.C.
Dr. Lauren L. Jorgensen, D.C
Phone: 724-662-4299
Fax: 724-662-5800

Name: _____ (M/F) Do You Want to Receive Text Reminders? (Y/N)_____

Address _____City_____ State_____ Zip_____

Home Phone #: _____Work Phone #: _____Primary #: (Circle) Home Work Cell

Cell #:_____Email Address:_____

Age: _____ DOB: _____ # of Children:_____

Marital Status: M/S/W/D Spouse's Name and Contact #_____

Emergency Contact and # : _____ Your Occupation:_____

Employer/Company Name and Address:_____

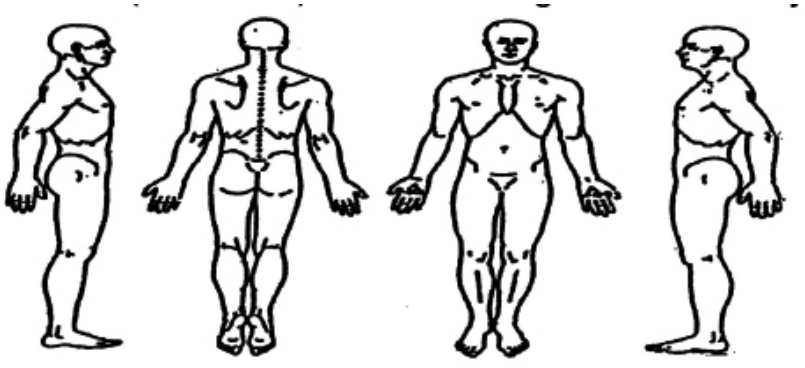
**How did you hear about our office? _____ Referring Doctor: _____

Main Complaint:_____

Other Complaints:_____

1. Is today's problem caused by: circle Auto Accident Workman's Compensation
Other_____

2. Indicate (circle or X) on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms? Circle

Constantly (76-100% of the time) Occasionally (26-50% of the time)

Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain? Circle

Sharp Numb Dull Tingly Sharp with motion

Achy Shooting with motion Burning Stabbing with motion Shooting Electric like with motion

Stiff Other:_____

5. How are your symptoms changing with time? Circle

Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work? Circle

Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities? Circle

Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem? Circle

Chiropractor Neurologist Primary Care Physician ER physician Orthopedist Massage Therapist
Physical Therapist No one Other:_____

10. How long have you had this problem?_____

11. How do you think your problem began?

_____

12. What aggravates your problem?

_____

13. What alleviates your problem?(makes it feel better)

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____

16. How would you rate your overall Health? Circle

Excellent Very Good Good Fair Poor

17. What type of exercise do you do? Circle

Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

19. List all prescription medications you are currently taking:

_____

20. List all of the over-the-counter medications you are currently taking:

_____

21. List all surgical procedures you have had:

_____

21. What activities do you do at work? Circle

Sit: Most of the day Half the day A little of the day

Stand: Most of the day Half the day A little of the day

Computer work: Most of the day Half the day A little of the day

On the phone: Most of the day Half the day A little of the day

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? No Yes If yes, why

_____

25. Have you had significant past trauma? No Yes If yes, please describe

_____

26. For each of the conditions listed below, please circle the **"pa"** if you have had the condition in the **past**. If you **presently** have a condition listed below, please circle **"pr".**

(Pa)Past (Pr)Present

Pa Pr Headaches
Pa Pr High Blood Pressure
Pa Pr Diabetes
Pa Pr Neck Pain
Pa Pr Heart Attack
Pa Pr Excessive Thirst
Pa Pr Upper Back Pain
Pa Pr Chest Pains
Pa Pr Frequent Urination
Pa Pr Mid Back Pain\
Pa Pr Stroke
Pa Pr Smoking Tobacco Use
Pa Pr Low Back Pain
Pa Pr Angina
Pa Pr Drug/Alcohol Dependence
Pa Pr Shoulder Pain
Pa Pr Kidney Stones
Pa Pr Allergies
Pa Pr Elbow/Upper
Pa Pr Arm Pain
Pa Pr Kidney Disorders
Pa Pr Depression

Pa Pr Wrist Pain
Pa Pr Bladder Infection
Pa Pr Systemic Lupus
Pa Pr Hand Pain
Pa Pr Painful Urination
Pa Pr Epilepsy
Pa Pr Hip Pain
Pa Pr Loss of Bladder Control
Pa Pr Dermatitis/ Eczema/Rash
Pa Pr Upper Leg Pain
Pa Pr Prostate Problems
Pa Pr HIV/AIDS
Pa Pr Knee Pain
Pa Pr Abnormal
Pa Pr Weight Gain/ Loss
Pa Pr Ankle/Foot Pain
Pa Pr Loss of Appetite
Pa Pr Jaw Pain
Pa Pr Abdominal Pain
Pa Pr Joint Pain/ Stiffnes
Pa Pr Ulcer
Pa Pr Arthritis

Pa Pr Hepatitis
Pa Pr Rheumatoid Arthritis
Pa Pr Liver/Gall Bladder Disorder
Pa Pr Cancer
Pa Pr General Fatigue
Pa Pr Tumor
Pa Pr Muscular In-coordination
Pa Pr Asthma
Pa Pr Visual Disturbances
Pa Pr Chronic Sinusitis
Pa Pr Dizziness

For Females Only
Pa Pr Birth Control Pills
Pa Pr Hormonal Replacement
Pa Pr Pregnancy
Pa Pr Cramping

Other_____
_____

27. Anything else pertinent to your visit today?_____
_____
_____

Patient Signature_____Date:_____