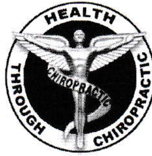


DR. JEFF DAVIS
CHIROPRACTIC
52 HERITAGE COURT
WOODCLIFF LAKE, NJ 07677
TEL: 201.664.9020

Patient Health Assessment

General Information

Patient Name______________________________________ Date____________

Patient Address____

City______________________________ State__________ Zip Code__________

Home Phone #______________ Work Phone#______________ Cell#______________

E-mail address________________________ Date of Birth____________________

Name of Insured (if other than you)_____________________________________

Health Insurance Plan_____________ Group#___________ Member ID#____________

Other Health Insurance____

Symptom/Condition History

1) Please describe your current condition and how the problem began____________
____

2) How long have you had this problem? ___________________________________

3) How would you describe your pain?

Sharp	Soreness	Throbbing	Tingling	Dull	Stiffness
Spasm	Burning	Ache	Weakness	Numbness	Shooting

4) How would you rate the intensity of your pain right now? (Circle a number)

0 1 2 3 4 5 6 7 8 9 10
(minimal) (mild) (moderate) (severe) (unbearable)

5) How often is the pain present during your waking day? (Check appropriate box)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6) Since your problem began, is your pain

Getting better Getting worse Staying the same

7) How did your problem begin? ______________________________

Auto accident Work related accident Other type of accident

Gradual Sudden No specific reason

8) What makes your problem better?

Nothing Walking Standing Sitting Lying down Moving Rest

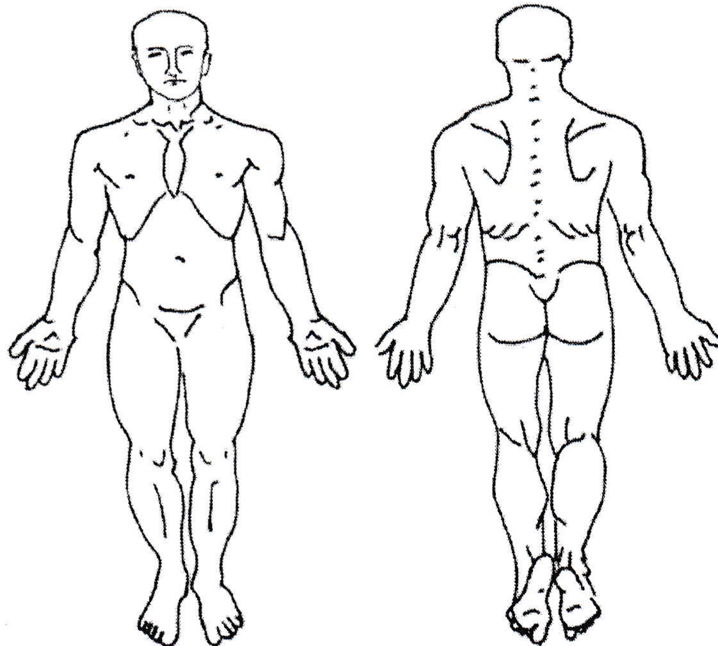
9) What makes your problem worse?

Nothing Walking Standing Sitting Lying down Moving Rest

10) Are you currently taking any medications for this condition or any other conditions?______________________________

____

Please shade in the area(s) that you have pain or a complaint.



Signature______________________________ Date______________