CHIROPRACTIC WELLNESS CENTER
9689 Main Street, Suite B
Fairfax, Virginia 22031
(703) 323-0068
www.cwcenter.com

NEW PATIENT INFORMATION FORM

Please print clearly:

Name ____ Date __________________

Address ____ Apt.# _________________

City _____________________________________ State ____________ ZIP _____________________

Home Phone (_______) _______ - ___________ Work Phone (______) _______ - ________________

Cell Phone (_______)________-__________ e-mail address: _________________________________

REFERRED BY: ____

Occupation ___________________________ Employer _______________________________________

Date of Birth _____________________ Age ______ Sex: M / F Height ________ Weight ________

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _______________________________

Chief complaint (reason you are here): (use separate sheet if more room needed)

____

Previous treatments for this complaint ____

____

Other Complaints or problems: (use separate sheet if needed) __________________________________

____

Current medications/drugs being taken: (use separate sheet if needed) ___________________________

____

Are you currently under the care of a physician or other health care professionals? (if yes, please give name and date of last visit):

____

Nutritional supplements you are taking: ____

Do you smoke, drink, coffee or alcohol? (if yes indicate how much)

Cigarettes ____________ Coffee ________________ Alcohol _________________

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HISTORY:

List any major illnesses (with approx. dates): ____

____

List any surgery or operations with approx. date: ____

____

Past Accidents or injuries: ____

____
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Marital Status: S M D W Name of Spouse ____

Describe health of spouse: ______________________________ Number of children if any _________

Name of Child	Age	Sex	Any physical conditions or concerns?
_________________________	____	____	____
_________________________	____	____	____
_________________________	____	____	____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other __

____

Any household pets or other animals you or family members are in close contact with: _____________

____

What can we do to make you happier? ____

____

SIGNED: ____ DATE: _______________

Office Only: