CHIROPRACTIC WELLNESS CENTER
9689 Main Street, Suite B
Fairfax, VA 22031
(703) 323-0068

(PLEASE PRINT)

PATIENT HISTORY

Name: ____ Date: ____________________________ Gender: M / F
(first, middle, last)

Address: ______________________________________ City: ______________________ State: ______ Zip: ____________

Home Phone: (______)_______________ Cell Phone: (______)_______________ Work Phone: (______)_______________

Date of Birth: _______________ Social Security Number: _____________________ Email Address: ___________________

Place of Employment: ____________________________ Occupation: ____

Relationship status: _____________________________ Spouse or Partner's name: __________________________________

Children's names and ages: ____

Hobbies and Activities: ____

Have you been under Chiropractic care before? Yes / No How long ago? ____

What is the area of your primary pain: ____

How and when did it originate (injury, gradual, sudden – give details)? ____

____

Please indicate site(s) of pain on picture at the right:
Type of pain:

__ Aching __ Sharp

__ Burning __ Shooting

__ Constricting __ Spasm

__ Cramps __ Stinging

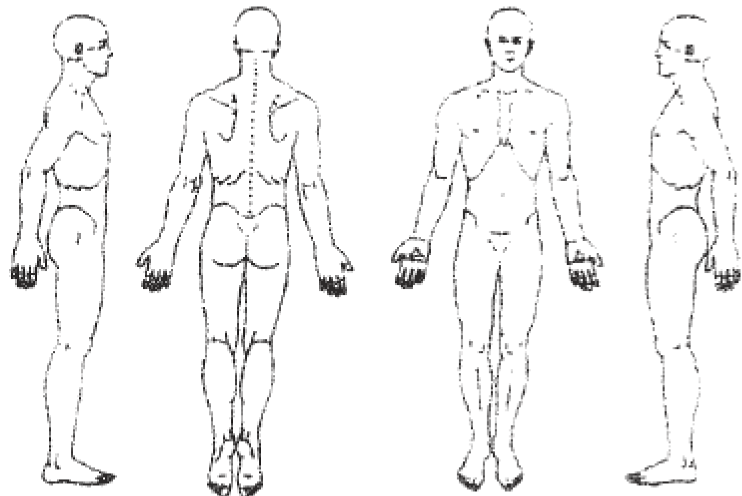
__ Dull __ Swelling

__ Numbness __ Throbbing

__ Pounding __ Tingling

Other : __________________________________

____



Frequency of symptom during a day: (place a check)
__ 0-25% Intermittent __ 26-50% Occasional __ 51-75% Frequent __ 75-100% Constant

Intensity: (place a check)
__ Minimal-none __ Slight-some __ Moderate-serious __ Marked-prevents
From a scale of 1-10, 10 is unbearable. How do you rate the symptom now? 1 2 3 4 5 6 7 8 9 10

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Have you ever had symptoms similar to your primary or secondary conditions? YES / NO. If yes, when was the last time they bothered you?

Please check any of the following if they concern you at present:

___Fatigue ___Blurred vision ___Double vision ___Dizziness

___High Blood Pressure ___Slurred Speech ___Fainting ___Ear infections

___Sinus problem ___Ringing/Buzzing in ears ___Allergies ___Asthma

___Diabetes ___Chest Pain ___Back Pain ___Neck Pain

___Shoulder pain ___Headache ___Prostate ___Urinary problems

___Digestive problems ___Constipation ___Diarrhea

___Leg or Foot pain, numbness, or tingling ___Arm or hand pain, numbness, or tingling

___Menstrual or other female concerns ___Other: ______________________________

____

List any surgeries (give year): ____

List any serious past accidents (give year): ___________________________________

List any medications you are presently taking: _________________________________

Do you have a history of heart disease, cancer or arthritis (please give detail)? ______________________

Describe the HEALTH goals you would like to achieve through this office:______________________

____

Whom may we thank for referring you to our office? ____________________________

What is the name and address of your family medical physician? ____________________________

I hereby give my permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of chiropractic and its adjunctive procedures following initial consultation, examination and consent. The doctor will not be held responsible for any pre-existing diagnosed condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment unless prior arrangements are made. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS

Patient's Name: ____

Patient's/Guardian's Signature: ______________________________ Date: ____________________

IT'S THE POLICY OF THIS OFFICE THAT PAYMENT IS DUE AT THE TIME OF SERVICE