VIENNA CHIROPRACTIC ASSOCIATES, P.C. PHONE: 703-938-6441

P.O. BOX 1634, VIENNA, VA 22183 FAX: 703-319-3978

PATIENT HISTORY AND APPLICATION FOR CHIROPRACTIC CARE (*Print, fill in, & bring to first visit*)

DATE:_____ SOCIAL SECURITY #_____

PATIENT NAME_____ REFERRED BY_____

HOME ADDRESS_____ WHERE DO YOU WORK?_____

CITY/STATE/ZIP_____ OCCUPATION_____

UNIT #_____ HOME PHONE_____

BIRTH DATE_____ CELL #_____

IF A MINOR, NAME/ADDRESS OF RESPONSIBLE ADULT:_____

"I GIVE PERMISSION FOR THIS MINOR TO BE SEEN AT THIS OFFICE":

SIGNATURE:_____ RELATION TO PATIENT:_____

# # #

REASON FOR TODAY'S VISIT:_____ PLEASE GIVE TODAY'S PROBLEM A NUMBER, WITH "10" BEING THE MOST SEVERE AND "1" MOST MINIMAL EXPRESSION:_____

WHEN DID THE PROBLEM START:_____

Note: If today's visit is related to an auto accident or worker's compensation case, please stop writing and request the appropriate forms. Without these, we cannot file your claim.

HAVE YOU HAD THIS BEFORE?_____

IF SO, DOES TODAY'S PROBLEM FEEL ANY DIFFERENT?_____

HAVE YOU BEEN OUT OF WORK DUE TO THE ABOVE?_____

WHEN?_____

FULL OR PART TIME?_____

Patient Name:_____

DO ANY OF YOUR CURRENT PROBLEMS INTERFERE WITH THE WAY YOU GO ABOUT YOUR DAY; IN WHAT WAY?_____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE?_____

MOST RECENT ADJUSTMENT_____TECHNIQUES THAT WORKED BEST_____

PRESCRIPTION OR OTC MEDICATION (LIST SEPARATELY IF NECESSARY):_____

_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

_____HEART DISEASE _____SEIZURES _____ALLERGIES ____GALL BLADDER DISEASE _____ARTHRITIS

_____HIGH BLOOD PRESSURE _____DIABETES _____STROKE _____ULCERS _____CANCER

_____TB _____KIDNEY DISEASE _____HEADACHE _____ASTHMA _____FAINTING

_____CONCUSSION _____COVID _____ADVERSE DRUG/VACCINE REACTIONS

NOTES ON ABOVE:_____

FAMILY HISTORY:

AGE OF MOTHER_____ AGE OF FATHER_____ HAS ANY DIRECT RELATIVE HAD ANY OF THE FOLLOWING:

_____HEART DISEASE _____HIGH BLOOD PRESSURE _____ARTHRITIS _____ULCERS _____DIABETES

_____TB _____GALL BLADDER DISEASE _____KIDNEY DISEASE _____CANCER _____ASTHMA

_____FAINTING _____ALLERGIES _____EPILEPSY/SEIZURES _____OTHER

NOTES ON FAMILY HISTORY:_____

WHEN WAS YOUR MOST RECENT PHYSICAL EXAMINATION_____

SIGNIFICANT RESULTS_____

GYNECOLOGICAL HISTORY:

AGE AT ONSET OF PERIOD_____ # OF DAYS TYPICAL PERIOD LASTS_____ PAIN?_____

NUMBER OF PREGNANCIES_____ NUMBER OF CHILDREN_____

GYN PROBLEMS_____

PATIENT NAME:_____

SURGICAL HISTORY:

DESCRIBE ANY AND ALL SURGERIES:_____

TRAUMA HISTORY:

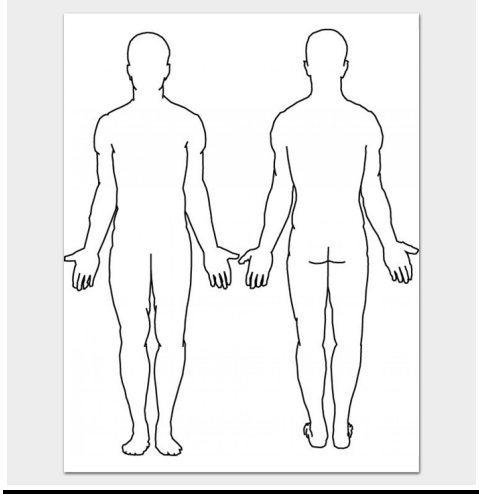
DESCRIBE ANY TRAUMA (WHIPLASH, FALLS, BLOWS, MAJOR SPORTS INJURIES), REGARDLESS OF AGE AT THE TIME, INCLUDING CARE RECEIVED:_____

PHYSICAL ATTACKS/ABUSE:_____

DESCRIBE ANY BROKEN BONES:_____

SYMPTOMS

SHADE IN AREAS OF PAIN OR ABNORMAL SENSATION:



CHECK ANY OF THE FOLLOWING YOU HAVE EVER HAD:

_____NECK PAIN[1] _____PAIN BETWEEN THE SHOULDER BLADES[2] _____LOW BACK PAIN[3]
_____WEAKNESS[4] _____POOR BALANCE[5] _____PARALYSIS[6] _____COLDS[7] _____INSOMNIA[8]

PATIENT NAME:_____

SYMPTOMS CONTINUED

_____STOMACH PAIN[9] _____POOR APPETITE[10] _____BOWEL PROBLEMS[11]

_____URINARY PROBLEMS[12] _____GENERAL POOR HEALTH1[3] _____JAW PAIN[14] _____ITCHING[15]

_____RINGING IN THE EARS1[6] _____KNEE PAIN[17] (LEFT OR RIGHT) _____ELBOW PAIN[18] (L OR R)

_____SHOULDER PAIN[19] (L OR R) _____LEG PAIN[20] (L OR R) _____ARM PAIN[21] (L OR R)

_____FOOT PAIN[22] (L OR R) _____HAND PAIN[23] (L OR R) _____UNEXPECTED WEIGHT LOSS[24]

_____NAUSEA/VOMITING[25] _____DIZZINESS[26] _____SHORNTESS OF BREATH[27]

_____NUMBNESS/TINGLING[28] (WHERE?_____) _____VISUAL D IFFICULTY[29]

_____HEARING PROBLEMS[30] _____DIFFICULTY SWALLOWING[31] ___UNEXPECTED WEIGHT LOSS

_____TROUBLE TAKING DEEP BREATH[32] _____DIFFICULTY SPEAKING[33]

NOTES ON SYMPTOMS:_____

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FEARS ABOUT YOUR HEALTH OR THIS VISIT:

OTHER HEALTH CARE PROVIDERS YOU HAVE SEEN THIS YEAR:_____

##

TIME OF DAY YOU FEEL BEST: _____ WORST:_____

DO YOU SMOKE_____ DRINK_____ USE RECREATIONAL DRUGS_____

WHAT EXERCISE DO YOU GET?_____

COUNSELING/SELF-IMPROVEMENT PROGRAMS_____

HOW DO YOU RELAX?_____

UNEXPECTED ATTACKS OF ANXIETY/DEPRESSION/FATIGUE?_____

ANY UNUSUAL STRESS RIGHT NOW?_____

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YOUR SIGNATURE:_____

TODAY'S DATE:_____