

FAMILY CHIROPRACTIC CENTERS

Account # _____



Fairfax • Springfield • Woodbridge

GENERAL ACCOUNT

CONFIDENTIAL PATIENT INFORMATION

Date _____
First Name _____ M.I. _____ Last Name _____
Address _____
City _____ State _____ ZIP _____
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
E-Mail _____ Birthdate ____/____/____ Age ____ Sex M F SSN ____-____-____
Employer _____ Occupation _____
Name of Spouse _____ Employer _____
Occupation _____ Work Phone (____) _____
Nearest Relative _____ Phone (____) _____
Referred to this office by _____
How do you prefer to be addressed: Mr. Mrs. Miss Ms. Dr. First Name Other _____

ACCOUNT INFORMATION

PATIENT'S PRIMARY HEALTH INSURANCE

Policy holder's Name _____ DOB _____ SSN _____
Insurance Company _____ Phone (____) _____
Address _____
City _____ State _____ ZIP _____
Policy No. _____ Group Name/No. _____

PATIENT'S SECONDARY HEALTH INSURANCE

Policy holder's Name _____ DOB _____ SSN _____
Insurance Company _____ Phone (____) _____
Address _____
City _____ State _____ ZIP _____
Policy No. _____ Group Name/No. _____

Patient Name: _____ Account # _____

Please list the sports or physical activity you participate in _____

How often? More than once a week Once a week Once a month

Age of mattress _____ (Comfortable? or Uncomfortable?)

In which position do you sleep?

Stomach Right Side Left Side Back Other

<i>Have You Ever:</i>	Yes	No	<i>Do You:</i>	Yes	No	
Been knocked unconscious	<input type="checkbox"/>	<input type="checkbox"/>	Now take any medications	<input type="checkbox"/>	<input type="checkbox"/>	Type _____
Used a cane, crutch, other support	<input type="checkbox"/>	<input type="checkbox"/>	Take vitamins or minerals	<input type="checkbox"/>	<input type="checkbox"/>	Type _____
Been treated for a spine or nerve disorder	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>	Amount _____
Had any mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	Drink	<input type="checkbox"/>	<input type="checkbox"/>	Amount _____
Had any surgery	<input type="checkbox"/>	<input type="checkbox"/>	Have any drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	Type _____

Describe _____

FAMILY HISTORY

(Place the family member's corresponding number on the line before the disease they have or had)

1. Self 2. Father 3. Mother 4. Brother(s) 5. Sister(s) 6. Grandfather 7. Grandmother 8. Uncle 9. Aunt

_____ Diabetes	_____ High Blood Pressure	_____ Dizziness
_____ Cancer	_____ Low Blood Pressure	_____ Stroke
_____ TB	_____ Hypoglycemia	_____ Arteriosclerosis
_____ Heart Disease	_____ Thyroid	_____ Anemia
_____ Arthritis	_____ Backaches	_____ Epilepsy
		_____ Pleurisy

Have you ever been involved in an auto accident?

Past year _____ Past five years _____ Over five years _____ Never _____

Describe: _____

Have you had any personal injury or accident?

Past year _____ Past five years _____ Over five years _____ Never _____

Describe: _____

Date of last physical examination: _____

How would you characterize yourself: (Check all those that apply)

Normal _____ Nervous _____ Tense _____ Depressed _____ Cry easily _____ Quick Temper _____

Other _____

Patient Name: _____

Account # _____

HEALTH INFORMATION

Have you had previous chiropractic care? _____

Where? _____ When? _____

What is your major complaint? _____

Other complaints _____

When and how did your major complaint first appear? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? Y N

When? _____

PCP name, address and phone number _____

Other doctors who have treated this condition _____

Since this condition began, is it Better Worse Unchanged

What part of the day is most painful? _____

Please check the appropriate box to describe your present limitations in function:

Please mark your area(s) of pain (P), numbness(N), tingling(T) on the figure below and note the severity of pain on the following scale.

No Pain Unbearable Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Activity	Normal	Mildly Limited	Moderately Limited	Severely Limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Present Occupation _____ How long have you had this job? _____

Type of activity involved Sitting Moderately Active Heavy Labor

List any previous jobs during the past two years (specify dates) _____

Activity when not working _____

