Family Chiropractic of Fairfax:
A Creating Wellness Center

10831 Main St.
Fairfax, VA 22030

Tel (703) 273-7733
Fax (703) 385-9693
Website: familychiropracticoffairfax.com

GENERAL ACCOUNT

CONFIDENTIAL PATIENT INFORMATION

Date_____/_____/_____

First Name_____M.I._____Last Name_____

Address_____

City_____State_____ZIP_____

Home Phone (_____)_____Cell Phone (_____)_____Work Phone (____)_____

E-Mail_____DOB___/____/____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._____

GENERAL HISTORY

Creating Wellness Lifestyle patients only, please start at ★

Have you had previous chiropractic care? _____

Where? _____ When? _____

What is your major complaint? _____

_____

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? _____

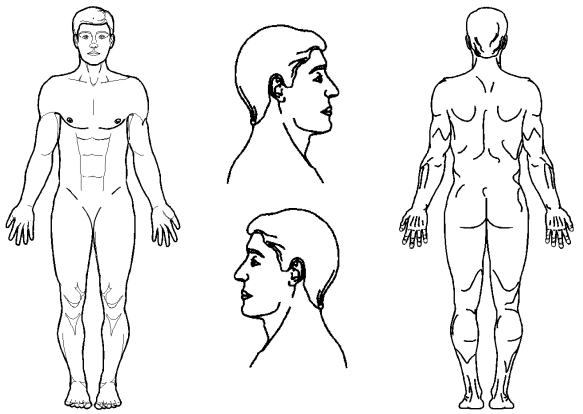
Since this condition began is it: Better Worse Same

What part of the day is most painful? AM PM

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



PCP name, address, phone number_____

_____

Other doctors who have treated this condition?_____

_____

★ Please list any medications you take regularly and why (prescription and non-prescription). _____

_____

Have you had any surgeries or been hospitalized? No If yes, describe briefly_____

_____

Have you ever had any work- related injury(ies)? No If yes, describe briefly_____

_____

_____

Have you ever had any major slips, falls or auto accidents? No If yes, describe briefly _____

_____

_____

Use a scale of 1 to 10 (1=none, 10=extreme)

and briefly describe your emotional/ psychological/lifestyle stress levels in the following areas:

Occupational Stress level = ___ , Briefly describe _____

_____

Personal Stress level= ___, Briefly describe_____

_____

Please check all symptoms you currently have or recently have had:

__ Headaches	__ Buzzing in ears	__ Irritability	__ Diarrhea
__ Pins and needles in arms	__ Ringing in ears	__ Cold hands	__ Cold sweats
__ Pins and needles in legs	__ Numbness in toes	__ Cold feet	__ Mood swings
__ Dizziness	__ Depression	__ Fever	__ Loss of smell
__ Numbness in fingers	__ Constipation	__ Urinary problem	__ Loss of taste
__ Fatigue	__ Menstrual cramps	__ Fainting	__ Back pain
__ Sleeping problems	__ Menstrual irregularity	__ Eyes bothered by light	__ Neck pain
__ Tension	__ Hot flashes	__ Stomach upset	__ Stiff neck
__ Ulcers	__ OTHER (briefly describe) _____		

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

Type of activity involved Sitting Moderately Active Heavy Labor

List any previous jobs in the last 2 years (specify dates) _____

_____

Activity when not working _____

Please list the sports or other physical activities 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 All Over Other _____

Have you ever:	Yes	No	**Do you**:	Yes	No	
been knocked unconscious?	__	__	take vitamins or supplements?	__	__	Type_____
used a cane, crutch, other support?	__	__	smoke?	__	__	Amount _____
			drink?	__	__	Amount _____
been treated for a spine or nerve disorder?	__	__	have any drug allergies?	__	__	Type _____
			drink ½ your weight (in lbs.) in ounces of water daily	__	__	

FOR WOMEN ONLY

Number of days from the beginning of one period to the beginning of the next period _____

Date of last menstrual period _____ How many days do you usually menstruate? _____

Are you pregnant? __ Yes __ No Do you use __ Birth control pills? __ Diaphragm? __ IUD?

YOUR GOALS

We're committed to supporting you in achieving your best vision of yourself and your life. Please take a few moments to answer the following questions.

1. How do you feel in your body? (energy, weight, flexibility, etc.)_____

_____

2. Are you craving some foods more than others? Which ones? _____

_____

3. Do you experience any discomfort after eating certain foods? (bloat, headaches, fatigue, etc.)_____

4. Is there something that seems to get in the way of you feeling your best? (physically, emotionally)_____

_____

5. Have you asked for support in the past? Please describe._____

_____

6. What are the 3 most important changes you would like to see for yourself in the next 3-6 months? _____

_____

Are there any other health concerns you think the doctor would need to know? _____

_____

Thank you for providing the information to begin your journey into the Creating Wellness Lifestyle!

Patient's Signature_____ Date_____

DOCTOR'S NOTES

_____

_____

_____

_____