



The Chiropractic Associates, LLC

1240 North Pitt St • Alexandria VA 22314

Phone: 703-739-0456 • Fax: 703-739-0032

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patients: Please complete this questionnaire. Your answers will help us determine if chiropractic care can benefit you. If we do not sincerely believe your condition will respond satisfactorily, we reserve the right to not accept your case. **THANK YOU!**

Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Age: _____ Birth Date: _____ Marital Status: S M D W P # of Children: _____

Occupation: _____ Spouse or Partner's Name: _____

Referred By: _____ Emergency Phone: _____

HEALTH INFORMATION:

Date of last physical examination: _____

Have you had prior chiropractic care? Yes No If yes, when? _____

What is your major complaint? _____ Onset of complaint/condition(s): _____

How long have you had this condition? _____ Have you had this conditions in the past? Y N

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and Goes

Is this condition interfering with: Work Sleep Daily Routine Other: _____

Do other family members have similar problems? Yes No

Please list: _____

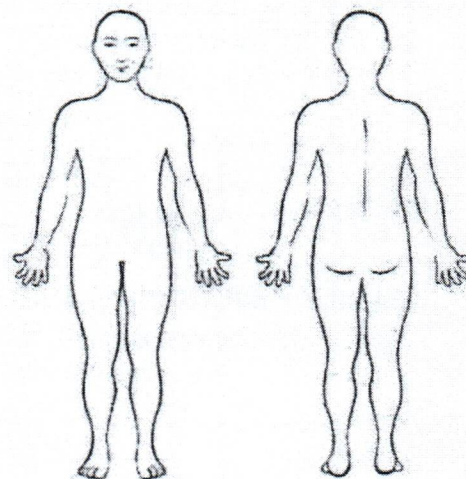
Other doctors who have treated this condition? _____

List any surgical procedures and years: _____

List any drugs you are currently taking: _____

Are you wearing foot/arch supports/heel lifts? Yes No

Age of your mattress? _____ Comfortable Uncomfortable



Please outline on the diagram the area of your discomfort.

FEMALE ONLY: Is there any chance that you may be pregnant? Yes NO



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Have you ever been involved in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

Have you had any other accident(s) or personal or job related injury? Past year Past 5 years Over 5 years Never

Describe: _____

Have you suffered from?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Pain between Shoulders |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Pain Down Back or Leg |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Menstrual pain / irregular | <input type="checkbox"/> Pins & Needles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Ringing / Buzzing ears |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Hand / finger / wrist pain | <input type="checkbox"/> Mood Swings / Depression | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cold Feet / Cold Hands | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Hip / Thigh Pain | <input type="checkbox"/> Numbness in fingers / hands | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Numbness in toes / feet | <input type="checkbox"/> Other: _____ |

AUTO ACCIDENT/MEDICARE:

Is your condition due to an auto accident or job related injury? Yes No

Are you covered by Medicare? Yes No If **YES**, please provide Medicare # _____

Non-participating Provider with Insurance

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic Associates will prepare any necessary reports and forms to assist me in making collection 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 all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Date: _____

Guardian or Spouse's Signature: _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health).

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

THE CHIROPRACTIC ASSOCIATES

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working with the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

As a chiropractic patient, it is important that you are always aware of some terminology that will be used in practice. This will give you a better understanding of chiropractic care.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if, during a chiropractic spinal examination, we encounter non-chiropractic or usual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference in the expression of the body's innate wisdom to heal itself. Our only method is specific adjusting to correct vertebral subluxation.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor / child:

I, _____, Being the patient or legal guardian, have read and fully understand the above terms of acceptance and hereby grant permission of my child to receive chiropractic care.

PLEASE SIGN BACK

MISSED APPOINTMENTS / CANCELLATIONS POLICY

WE PROVIDE SERVICES BY APPOINTMENT ONLY

IF YOU CANNOT MAKE YOUR APPOINTMENT,
PLEASE GIVE US 24 HOURS NOTICE TO AVOID BEING
CHARGED \$50.00 FOR THE TIME YOU HAVE RESERVED

IF YOU NEED A DETAILED REOPT OR TREATMENT
OR FOR AN ACCIDENT CASE, AND ADDITIONAL FEE OF \$80.00
WILL BE CHARGED.

PATIENT NAME:

PATIENT SIGNATURE:

DATE:
