



## CONFIDENTIAL HEALTH HISTORY

1240 North Pitt St # 100  
Alexandria , VA 22314  
703-739-0456  
www.chiroassoc.net

### PATIENT INFORMATION:

Name: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Parent Name: \_\_\_\_\_  
Mother's Telephone: \_\_\_\_\_ Father's Telephone: \_\_\_\_\_  
Referred By: \_\_\_\_\_

### CHILD'S MEDICAL HISTORY:

How is your child's general Health?      **EXCELLENT**    **GOOD**    **FAIR**    **POOR**  
Briefly describe your child's primary health concerns: \_\_\_\_\_  
\_\_\_\_\_  
Have your child had nutrition consultation care previously? If yes, When? \_\_\_\_\_  
\_\_\_\_\_  
What concerns do you have about your child's diet? \_\_\_\_\_  
\_\_\_\_\_



Please check whether your child currently has or has ever had , any of the following: ( check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Irregular Heartbeat     |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Hormone disorder        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Frequent stomachaches   |
| <input type="checkbox"/> Eczema - Hives      | <input type="checkbox"/> Changes in appetite     |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Blood pressure concerns |
| <input type="checkbox"/> Bowel Problems      | <input type="checkbox"/> Mood swings             |
| <input type="checkbox"/> chronic illnesses   | <input type="checkbox"/> Panic Attacks           |
| <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Weight loss             |

Other not listed above: \_\_\_\_\_

Please list all of your child's current medications, including prescription, over-the-counter and herbal remedies: \_\_\_\_\_

Significant medical problems, hospitalization or surgical operation: \_\_\_\_\_

**CHILD'S DEVELOPMENT HISTORY:**

Birth: ( circle): **Normal Delivery**      **Difficult Delivery**      **Cesarean Delivery**

Birth Weight: \_\_\_\_\_

Complications: \_\_\_\_\_

Goals you would like to achieve for your Child's Health: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**Consent to evaluate and Muscle Test a minor / child**

I, \_\_\_\_\_ the undersigning parent /guardian having legal custody/guardianship of \_\_\_\_\_ , a minor , do hereby authorize, request and direct Dr. \_\_\_\_\_

and whomever he/she might designate as assistant to perform in judgment and examination and muscle testing.

Any specific authorization you provide may be revoke at any time by writing to us at the address provided on the front of the form.

Patient: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ legal Guardian \_\_\_\_\_



# 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**

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**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: \_\_\_\_\_