



1240 NORTH PITT ST #100
ALEXANDRIA , VA 22314
703-739-0456
www.chiroassoc.net

CONFIDENTIAL HEALTH HISTORY

PATIENTS INFORMATION:

Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (C) _____ (W) _____

Email Address: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Occupation: _____ Emergency phone: _____

Hours of Work per week: _____

Spouse Name: _____ # of Children: _____ Marital Status: **S M D W P**

Referred By: _____

HEALTH INFORMATION:

Please list your main health concerns: _____

Goals: _____

Any serious illness/hospitalization/injures: _____

Parent Medical History: _____

What is your Blood Type: _____

Do you sleep well?(Yes or No) _____ How many hours? _____

Briefly describe sleep Patterns: _____

Check any of the following that you have or had.

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema - Hives | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Cancer (any) | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hernia |

Other: _____

Do you take any supplements or medications? If yes, please list:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Any healers, helpers or therapies with which you are involved? If yes, please list: _____

What role does sports and exercise play in your life? _____

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snack

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What's your food intake like these days?

Breakfast

Lunch

Dinner

Snack

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

Will family / friends be supportive of your desire to make food / or Lifestyle changes? _____

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:
