neck back & beyond

CASE HISTORY: **DATE:** _____

Name_____Age _____

Address _____

City _____ State_____ Zip_____

Phone (Cell)_____-_____-_____ Phone (Home/work)_____-_____-_____

Date of Birth_____-_____- _____

Sex: M F Marital Status: S M D W Social Security #_____-_____-_____

Email address: _____

Occupation_____Phone (Work)_____

Employer _____

Present condition due to an injury?_____Yes_____No_____On the Job _____ Auto Accident_____Other_____

Has the accident been reported?_____Yes_____No_____On the Job _____ Auto Accident_____Other _____

Reason for seeking care: _____

List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

_____

_____

Have you had similar accidents or injuries before?_____Yes_____No If yes, explain:

_____

List the names of any relatives that have or have had a similar problem: _____

Have you or any relative received chiropractic treatment previously?_____Yes_____No

If yes, explain: _____

10195 Main St. Ste.D
Fairfax, VA 22031
703.865.5690

www.neckbackandbeyond.com

9255 Centre St
Manassas, VA 20110
703.401.7333

neck back & beyond

Have you been treated for any health condition by a physician in the last year?

_____Yes_____No, if yes, explain: _____

Are you currently taking medication?_____Yes_____No

List conditions you are taking medications for: _____

List the approximate dates of any surgery or treated conditions:_____

_____

Family History: Health conditions, age of death and cause of death.

Father:_____

Mother:_____

Brother/s & Sister/s: _____

Do you smoke Y / N

Do you drink Alcohol Y / N_____Daily_____Weekly_____Social Occasions

Number of Caffeinated drinks per day _____

Do you take Vitamins/Supplements Y/N If yes, type and how often

_____

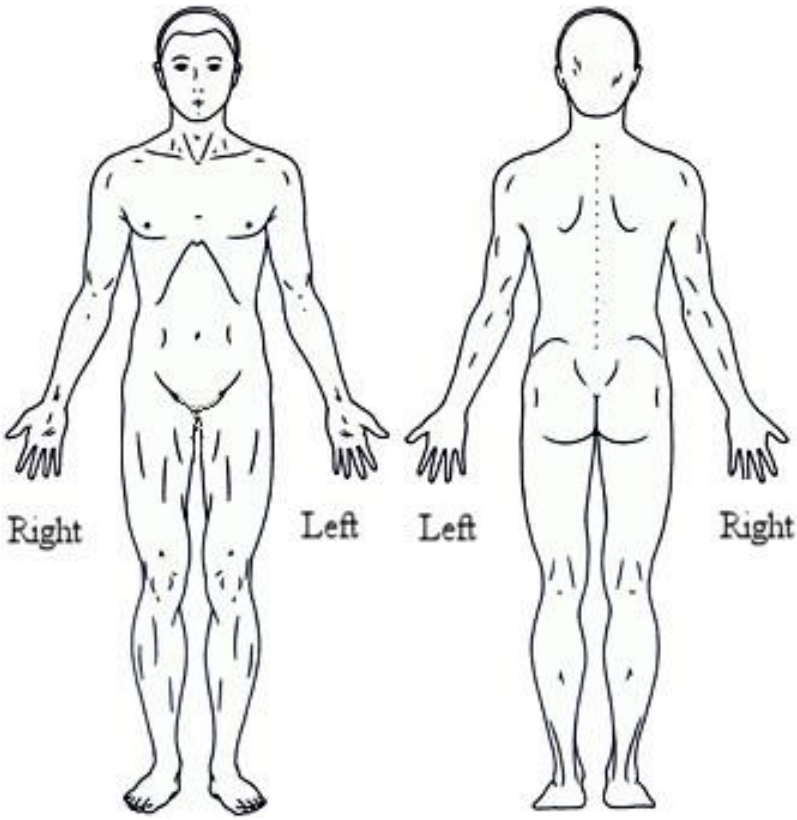
People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ I want the Doctor to select the type of care appropriate for my condition.
- ☐ Relief care: Symptomatic relief of pain or discomfort.
- ☐ Corrective care: Correcting and relieving the cause of the problem as well as the symptom.
- ☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

neck back & beyond

Mark on the pictures where you feel pain.

Please circle degree of pain: 0 none, 10 severe pain.



0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work?_____

Sleep?_____Routine?_____

Other?_____

Is this condition progressively getting worse? Y / N

Does this condition prevent you from performing everyday tasks? Please list:

_____

When did this condition/ pain begin?

_____

10195 Main St. Ste.D
Fairfax, VA 22031
703.865.5690

www.neckbackandbeyond.com

9255 Centre St
Manassas, VA 20110
703.401.7333

neck back & beyond

Please mark each item below for each sign or symptom you presently have/ previously had:

GENERAL SYMPTOMS
__Convulsions
__Dizziness
__Fainting
__Headache
__Nervousness
__Numbness
__Wheezing

MUSCLES & JOINTS
__Low Back Problems
__Pain between Shoulders
__Neck Problems
__Arm Problems
__Leg Problems
__Swollen Joints
__Painful Joints
__Stiff Joints
__Sore Muscles
__Weak Muscles
__Walking Problems
__Sprains/Strains
__Broken Bones

CARDIO-VASCULAR
__High Blood Pressure
__Heart Attack
__Pain over Heart
__Poor Circulation
__Heart Trouble
__Rapid Heart
__Slow Heart
__Strokes
__Swelling Ankles
__Varicose Veins

EAR/NOSE/THROAT
Earache
Ear Noises
Enlarged Thyroid
Frequent Colds
Hay Fever
Nasal Blockage
Nose Bleeds
Pain Behind Eyes
Poor Vision
Sinusitis
Sore Throats
Tonsillitis

GASTRO-INTESTINAL
Belching/Gas
Colon Problems
Constipation
Diarrhea
Excessive Hunger
Excessive Thirst
Gall Bladder Trouble
Hemorrhoids
Liver/Gallbladder
Nausea
Abdominal Pain
Ulcer
Poor Appetite
Poor Digestion
Vomiting
Vomiting Blood
Black Stool
Bloody Stool
Weight Loss/Gain

RESPIRATORY
__Asthma
Chronic Cough
Difficulty Breathing
Spitting Blood
Spitting Phlegm

GENITO-URINARY
Blood in Urine
Frequent Urination
Kidney Infection
Painful Urination
Prostate Problems
Loss of Bladder Control

SKIN OR ALLERGIES
Boils
Bruising Easily
Dryness
_
Eczema/Rash/Dermatitis
Hives
Itching
Sensitive Skin
Allergy _____

FOR WOMEN ONLY
Birth Control _____
Hormone Replacement
Cramps/Backaches
Excessive Flow
Hot Flashes
Irregular Cycle
Miscarriage
Painful Periods
Vaginal Discharge
Breast Pain
Pregnant at this Time
Y/N

neck back & beyond

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

Patient Signature_____Date _____

10560 Main St. PH-1
Fairfax, VA 22030
703.865.5690

www.neckbackandbeyond.com

9255 Centre St. Ste: 301- B
Manassas, VA 20110
703.401.7333

neck back & beyond

VITALS (to be filled out by Dr.)

Height:_____'_____''

Weight:_____lbs

Blood Pressure:_____/ _____

Heart Rate:_____bpm

DEMOGRAPHICS

Are you a smoker?

Yes No

If yes, how often?

Every day Some days (a few times/ week) Rarely (1/week)

Ethnicity:

Hispanic/ Latino Asian Hawaiian or Pacific Islander Black/ African American

American Indian Alaskan Native White Other

MEDICATIONS

Please list any medications you are currently taking:

Medication	Generic name	Strength (mg)	Dosage/ Frequency	How taken?

ALLERGIES

Please list any drug allergies:

_____

_____

10560 Main St. PH-1
Fairfax, VA 22030
703.865.5690

www.neckbackandbeyond.com

9255 Centre St. Ste: 301- B
Manassas, VA 20110
703.401.7333