



# 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: \_\_\_\_\_



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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.

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

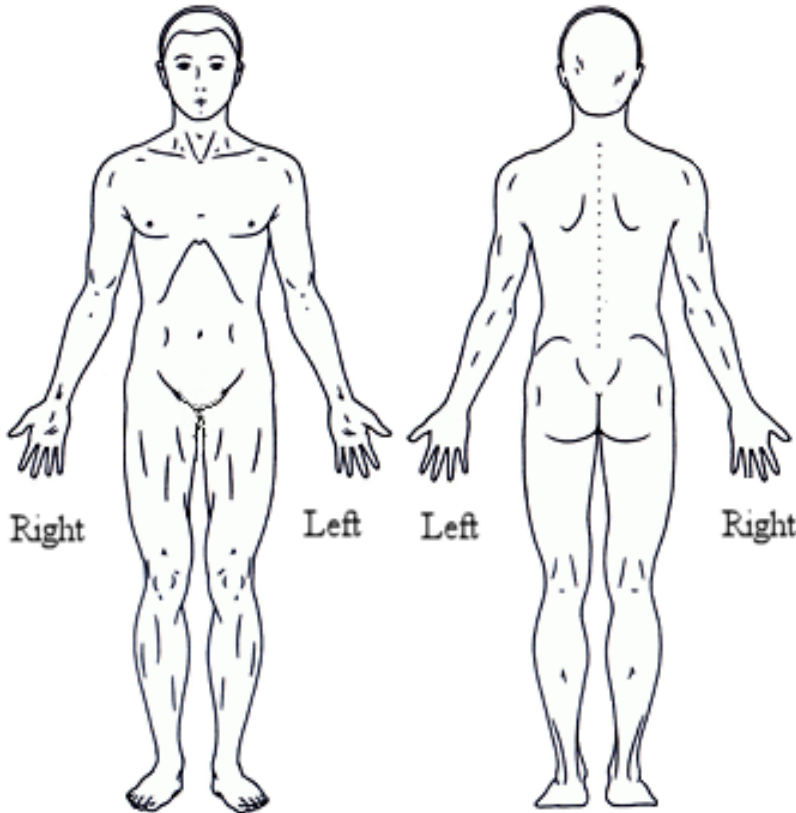
[www.neckbackandbeyond.com](http://www.neckbackandbeyond.com)

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



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?

---



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



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## 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) for which I seek treatment.

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



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**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:

_____
_____

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