

**Patient Information:**

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M( ), F( )  
 Home Address: \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Please, check the appropriate box:  Married,  Single,  Divorced,  Widow,  Minor  
 Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Phone Number( ) \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Occupation \_\_\_\_\_  
 What causes you more pain?  Walking,  Standing,  Lifting,  Turning,  Sitting,  Bending,  : \_\_\_\_\_  
 What makes you feel better?  Rest,  Medication,  Ice Packs,  Hot Showers,  Other: \_\_\_\_\_  
 Are you pregnant?( ) Yes, ( ) No; If Yes, when are you expecting? \_\_\_\_\_ If No, date of last period \_\_\_\_\_

**Medical History:**

*Virginia Family Chiropractic & P.T., PLLC*

5249 Duke Street #205  
**Alexandria**, VA 22304  
 Phone (703) 370-5300  
 Fax (703) 370-0080

14904 Jefferson Davis Hwy #301  
**Woodbridge**, VA 22191  
 Phone (703) 499-8840  
 Fax (703) 499-8842

8420 Dorsey Circle #101  
**Manassas**, VA 20110  
 Phone(703)367-7878  
 Fax (703) 367-0009

150 Little Falls #205  
**Falls Church**, VA 22046  
 Phone(703)538-3830  
 Fax (703) 538-3831

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Leg/Knee Pain     | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Ankle Pain        | <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> Foot Pain         | <input type="checkbox"/> Hepatitis A,B,C           | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Shoulder Pain      | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Herniated Disc/Bulge      | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Arm Pain           | <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> STD                  |
| <input type="checkbox"/> Forearm Pain       | <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Inguinal/Abdominal Hernia | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Wrist/Hand Pain    | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Muscle Pain        | <input type="checkbox"/> Breast Lumps      | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Tumors _____         |
| <input type="checkbox"/> Stiff Joints       | <input type="checkbox"/> Cancer _____      | <input type="checkbox"/> Lung Disease              | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Low Back Pain      | <input type="checkbox"/> Diabetes I, II    | <input type="checkbox"/> Meningitis                | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Mid Back Pain      | <input type="checkbox"/> Drug Abuse        | <input type="checkbox"/> Neurological Disorder     |   |
| <input type="checkbox"/> Upper Back Pain    | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Osteoarthritis            |   |
| <input type="checkbox"/> Thigh/Hip Pain     | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Osteoporosis              |   |

**Family History:**

Cancer,  Diabetes,  High Blood Pressure,  Heart Disease / Stroke,  Neurological Disorder,  Other \_\_\_\_\_

**List any old Injuries/Surgeries, describe with dates:** \_\_\_\_\_

**Today's visit is for:**

1. Auto Accident / Slip and Fall  ..... Section 1
2. Health Insurance / Cash  ..... Section 2

3. Worker's Compensation  .....Section 3