Purcellville Chiropractic Center

101-F South Maple Avenue
Purcellville, VA 20132
(540) 338-1663

CONFIDENTIAL PATIENT INFORMATION

Date_________/______/________________________

First Name_______________________________M.I.______Last Name________________________________

Address____

City____State_________ZIP_______________

Home Phone (_____)_____________Cell Phone (_____)_____________Work Phone (____)________________

E-Mail_____________________________DOB___/____/____Age_____Sex M F SSN________-______-_______

Employer_______________________________________ Occupation________________________________

Name of Spouse_________________________________ Employer_________________________________

Occupation____________________________________ Work Phone (______)_________________________

Emergency Contact ____________________________ Phone (_______)____________________________

Referred to this office by____

How do you prefer to be addressed: Mr. Mrs. Miss Ms. Dr. First Name Other ________________________

ACCOUNT INFORMATION

PATIENT'S PRIMARY HEALTH INSURANCE

Policy Holder's Name ______________________________DOB___/___/___SSN_______-______-__________

Insurance Company____Phone (_______)___________________

Address____

City______________________State_______ZIP_____________

Policy No.____Group Name/Number ______________________

PATIENT'S SECONDARY HEALTH INSURANCE

Policy Holder's Name ______________________________DOB___/___/___SSN_______-______-__________

Insurance Company____Phone (_______)___________________

Address____

City______________________State_______ZIP_____________

Policy No.____Group Name/Number ______________________

GENERAL HISTORY

Have you had previous chiropractic care? ____________

Where?____________________When? ______________

What is your major complaint? _____________________

____

When and how did your major complaint first appear?

____

What makes it better? ____________________________

What makes it worse?_____________________________

How long have you had this condition? ______________

Have you had this or similar conditions in the past? Y N

When? ____

Since this condition began is it: Better Worse Same

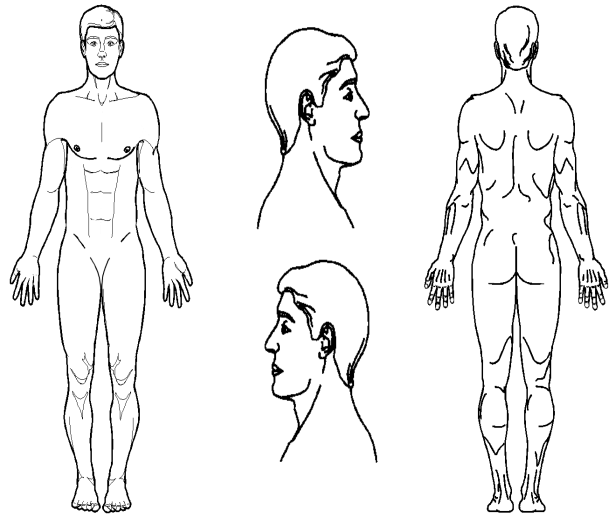
What part of the day is most painful? AM PM

Please Complete

Please mark your area(s) of Pain (P), burning (B)
Numbness (N), Tingling (T) on the figure below and note the severity of pain on the following scale.

No Pain **Unbearable Pain**

0	1	2	3	4	5	6	7	8	9	10



PCP name, address, phone number ____

____

Other doctors who have treated this condition?____

____

Please list any medications you take regularly and why (prescription and non-prescription). __________________

____

Have you had any surgeries or been hospitalized? No If yes, describe briefly ___________________________

____

Do you have a pacemaker? Yes No

Have you ever had any work-related injury(ies)? No If yes, describe briefly ___________________________

____

Have you ever had any major slips, falls or auto accidents? No If yes, describe briefly ____________________

____

____

Use a scale of 1 to 10 (1=none, 10=extreme) to briefly describe your emotional/ psychological/lifestyle stress levels in the following areas:

Occupational Stress level = _____, Briefly describe ______________________________

____

Personal Stress level= _____, Briefly describe ______________________________

____

Please check all symptoms you currently have or recently have had:

_______ Headaches	_______ Buzzing in ears	_______ Irritability	_______ Diarrhea
_______ Pins and needles in legs	_______ Ringing in ears	_______ Cold hands	_______ Cold sweats
_______ Pins and needles in arms	_______ Numbness in toes	_______ Cold feet	_______ Mood swings
_______ Dizziness	_______ Depression	_______ Fever	_______ Loss of smell
_______ Numbness in fingers	_______ Constipation	_______ Urinary problem	_______ Loss of taste
_______ Fatigue	_______ Menstrual cramps	_______ Fainting	_______ Back pain
_______ Sleeping problems	_______ Menstrual irregularity	_______ Neck pain	_______ Tension
_______ Eyes bothered by light	_______ Hot flashes	_______ Stomach upset	_______ Stiff neck
_______ Ulcers	_______ Other (briefly describe) ______________________________		

Present Occupation ______________________________ How long have you had this job? ______________

Type of activity involved: Sitting Moderately Active Heavy Labor

List any previous jobs in the last 2 years (specify dates) ______________________________

____

Activity when not working ______________________________

Please list the sports or other physical activities you participate in ______________________________

____

How often? More than once a week Once a week Once a month

Age of mattress ______________ Comfortable or Uncomfortable?

In which position do you sleep?

Stomach Right Side Left Side Back All Over Other ______________

Have you ever:	Yes	No
• been knocked unconscious?	____	____
• used a cane, crutch, other support?	____	____
• been treated for a spine or nerve disorder?	____	____

Do you:	Yes	No	
• take vitamins	____	____	Type ________________
• take supplements?	____	____	Type ________________
• smoke?	____	____	Amount ____________
• drink?	____	____	Amount ____________
• have drug allergies?	____	____	Type __________________

FOR WOMEN ONLY

Number of days from the beginning of one period to the beginning of the next period ________________________

Date of last menstrual period______________________How many days do you usually menstruate? _____________

Are you pregnant?____Yes ___No Do you use_____Birth control pills?_____Diaphragm?_____IUD?

YOUR GOALS

We're committed to supporting you in achieving your best vision of yourself and your life. Please take a few moments to answer the following questions.

1. How do you feel in your body? (energy, weight, flexibility, etc.) ______________________________

____

____

2. Is there something that gets in the way of you feeling your best? (physically and/or emotionally)

____

____

3. What are the 3 most important changes you would like to see for yourself in the next 3---6 months?

____

____

____

4. Are there any other health concerns or problems you would like to share?

____

Patient's Signature___________________________________Date _____________

DOCTOR'S NOTES

____

____

____

____