Spine Care Associates of Alexandria, Inc.
6285 Franconia Rd. 703-719-7302
Alexandria, VA 22310
www.SpineCareOfAlexandria.com

Date_____

NEW PATIENT DEMOGRAPHICS:

Name:_____ DOB:_____Age_____

Height: ___ ft___in_Weight:_____lbs

Address:_____SS#_____
City:_____State:_____Zip:_____Single/Married
Hm. #_____Wk.#_____ Cell.#_____
Email:_____

Employer:_____Occupation:_____
Emergency Contact: Name and Phone # _____
Ins.Name_____ Policy/Subscriber#_____Grp#_____

Referred By: Internet/ Phonebook/ Insurance/ Coupon/ Other/ Patient_____
Primary Care Phy._____ ph.#_____
Would you like a letter sent to your **Primary Care Physician? Y / N Name:**_____
Previous Chiropractic Care?**Y/N** If so how long ago?_____

MAIN COMPLAINT:

Why are you here today?(Please be specific)_____
_____

1.When did it start?_____ 2. How did it start?_____
3.Work related? **Y/N** , Auto Accident? **Y/N ,**Other Accident? **Y/N**
4.Does the pain radiate to any other part of your body , if so where?_____
5.Did your pain begin **Gradually**, or **Suddenly**?(Circle one)
6.Is your pain **Mild**, **Moderate**, or **Severe**? (Circle one)
7.Is your pain? Circle all that apply: **Dull, Sharp, Burning, Numbness, Soreness, Stiffness**.
8.Has your problem been getting **Better**, **Worse** or the **Same**?
9.Is your pain **Intermittent 25%/Frequent 50% /Constant 100% during the day**?
10.What makes your symptom **Better**?_____
Worse?_bending/lifting/computer/walking/sitting/standing/coughing/childcare/household chores/driving/getting dressed/intercourse/exercise/_____

11.Have you lost time from work?_____
12.Have you seen any other doctors for this?_____
13.Have you had this before? **Y/N** If so when?_____
14.Any changes in body function? **Explain**_____
15.Have you lost any work as a result of your current problem? **Y/N** How Long?_____
16.Do you have any other problem you would like the Dr. To evaluate?_____

PAST MEDICAL HISTORY

1. **XRAYS/MRI's when**?_____

2. Have you been diagnosed with any other conditions?_____
_____

3.Are you under a doctors care for any condition? **Y/N**_____

4. PREVIOUS TREATMENTS ? _____

5.Have you had any past significant auto accidents? **Y/N** When?_____
6.Please list any current medications you are taking._____
_____
_____

7. Have you under gone any surgeries? **Y/N** Explain._____
_____

8. Do you drink, smoke or use any recreational drugs? Explain._____
_____

9. Do you have any allergies? **Y/N** Explain._____
10. History of family diseases?
Explain._____
_____

Have you ever been diagnosed with any of the following? Please Circle Yes or No.

Y/N High Blood Pressure **Y/N** Hardening of the arteries
Y/N Diabetes **Y/N** Heart or blood vessel diseases
Y/N Bone spurs on neck **Y/N** Whiplash injury
Y/N Blurred or Double Vision **Y/N** Relatives who have suffered strokes
Y/N Currently Smoke **Y/N** Smoked in the past

Have you had any of the symptoms in the past Year?

Y/N Slurred speech or speech Problems **Y/N** Difficulty swallowing
Y/N Dizziness **Y/N** Temporary lack of understanding
Y/N Loss of consciousness, or Black out **Y/N** Numbness in face, arms, hands fingers, or legs
Y/N Any other abnormal loss of sensation **Y/N** Diminished or partial loss of vision
Y/N Weakness, Clumsiness or strength loss **Y/N** Hearing loss in one or both ears
Face, arms, hands, fingers, or legs

PAIN DRAWING:

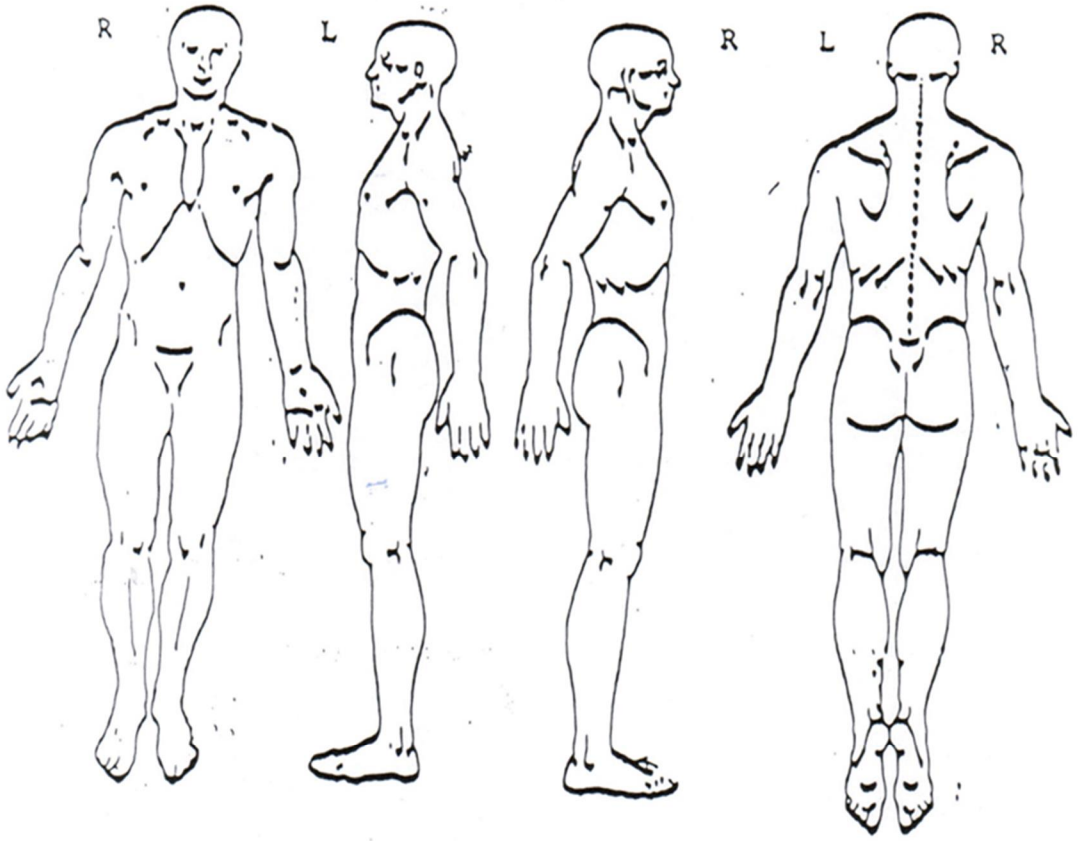
Circle the Severity of your pain on the line below:

0–1–2–3–4–5–6–7–8–9–10

(No pain) (Extreme pain)

Mark the location of your pain on the body outlines below using the following Letters:

A=Ache B=Burning N=Numbness P=Pins and Needles S=Stabbing X=Other(Specify)



Signature of Consent

I have read and understand the purpose of chiropractic care and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT I HAVE READ.
I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED.
I CONSENT TO RECEIVE THE CHIROPRACTIC CARE DEEMED NECESSARY BY THE DOCTOR.

I have also read the HIPAA Privacy pertaining to this office as well and collection procedures and release of medical information.

_____ _____

Date: Patient Name Printed

_____

Patient Signature

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person authorized to sign for Patient:

_____

Signature: _____

Relationship to Patient: _____