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**Quality Chiropractic**

6231 Leesburg Pike • Suite 200 • Falls Church VA 22044

(703) 237-0404 • fax (703) 237-7828

**Quality Chiropractic & Rehab**

102 Elden Street • Suite 12 • Herndon VA 20170

(703)581-8999 • fax (703) 481-0396

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**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRIMARY COMPLAINT**

**Area of Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Right Left Bilateral

**When did your complaint begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had this complaint previously?** Y (how long ago ) N

**What happened to cause or re-aggravate your complaint?**

Unknown Work Accident Auto Accident Sports Injury Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you received any recent treatment for this complaint?** Y N

**If yes, please list dates, treatment type, and doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your pain:** Achy Burning Dull Sharp Stiff Throbbing Stabbing Tightness Tingling

**Is your pain:** Mild Moderate Severe

**Please rate your pain:** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

**Is the pain:** Constant Frequent Intermittent Occasional

**Does the pain travel anywhere? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you experienced a change in any of the following since your symptoms began?**

 Bowel Function Bladder Function Sexual Function None

**What time of the day does it feel worse:** Morning Afternoon Evening While sleeping

**What aggravates your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What time of the day does it feel better:** Morning Afternoon Evening While sleeping

**What alleviates your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there numbness? Y N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there spasm? Y N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there any weakness? Y N Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there swelling? Y N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If your complaint involves headaches, please complete the following:**

**What is the location of your headaches:** Front Side Back Sinus

**What time of day does it feel worse:** Morning Afternoon Evening While sleeping

**How often do they occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** times per: Hour Day Week Month

**Please rate your pain:** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

**What is the duration of your headaches: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Minutes Hours Constant

**PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR SECONDARY COMPLAINT**

**Area of Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Right Left Bilateral

**When did your complaint begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had this complaint previously?** Y (how long ago ) N

**What happened to cause or re-aggravate your complaint?**

Unknown Work Accident Auto Accident Sports Injury Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you received any recent treatment for this complaint?** Y N

**If yes, please list dates, treatment type, and doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your pain:** Achy Burning Dull Sharp Stiff Throbbing Tingling Burning Other

**Is your pain:** Mild Moderate Severe

**Please rate your pain:** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

**Is the pain:** Constant Frequent Intermittent Occasional

**Does the pain travel anywhere? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you experienced a change in any of the following since your symptoms began?**

 Bowel Function Bladder Function Sexual Function None

**What time of the day does it feel worse:** Morning Afternoon Evening While sleeping

**What aggravates your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What time of the day does it feel better:** Morning Afternoon Evening While sleeping

**What alleviates your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there numbness? Y N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there spasm? Y N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there any weakness? Y N Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there swelling? Y N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s).**

**Numbness Tingling Burning Aching Stabbing**

**------------- oooooooooooo ^^^^^^^ XXXXX ////////////////**

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**Please mark any of the following conditions or symptoms that you have now or have experienced previously:**

O **AIDS/HIV** O **Insomnia** O **Infections** O **Polio**

O **Depression/Anxiety** O **Digestion Problems** O **Jaw pain/TMJ** O **Sinus condition**

O **Drug Abuse** O **TB** O **Dizziness** O **Anemia**

O **Liver disease** O **Asthma** O **Eye/ear disorder**

O **Arthritis** O **Diabetes** O **Prostate problems**

O **Cancer** O **Thyroid disease** O **High blood pressure**

O **Hernia** O **Kidney disease** O **Heart disease**

O **Stroke** O **Chest pain** O **Weight loss/gain**

**Please complete the following regarding medications/supplements that you are currently taking. If none of the above please write N/A**

|  |  |  |
| --- | --- | --- |
| **Date Started** | **Vitamin/Drug Name** | **Prescribed by** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list any allergies. If none of the above please write N/A**

|  |  |
| --- | --- |
| **Allergy** | **Reaction** |
|  |  |
|  |  |
|  |  |

**Please list any surgeries. If none of the above please write N/A**

|  |  |  |
| --- | --- | --- |
| **Date (Approximate)** | **Surgery** | **Facility** |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list hospitalizations, you can exclude surgery related if listed above. If none of the above please write N/A**

|  |  |  |
| --- | --- | --- |
| **Date (Approximate)** | **Reason** | **Hospital** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list any pertinent family history.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship** | **History** | **Deceased****Y/N** | **Cause of Death** |
| **Father** |  |  |  |
| **Mother** |  |  |  |
| **Brothers** |  |  |  |
| **Sisters** |  |  |  |
| **Children** |  |  |  |
| **Paternal Grandparent** |  |  |  |
| **Maternal Grandparent** |  |  |  |

**With whom do you currently live with:** Alone Spouse Spouse/Children(# ) Other

**Smoking Status:**  Never Current: Every day smoker Current: Some days smoker Former

**Alcohol Intake:** None Casual Moderate Severe

**Caffeine Intake:** None <3/day 3 to 6/day >6/day

**Recreational Drugs:** None Recreational User Addict

**Exercise Frequency:** None Daily 3-6x/week 1-2x/week

**Exercise Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently:** In School Employed (FT or PT) Unemployed Retired

**What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long have you been at your current job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently have a Primary Care Physician? Y N**

**Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been to a chiropractor prior to today’s visit? Y N**

**Date of your last chiropractic adjustment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FEMALE:**

**To the best of your knowledge are you pregnant? Y N**

**Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***To the best of my knowledge, all of the information completed above is correct.***

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**