

Dear Patient:

There are 4 pages following this cover sheet. These forms are an important step that allows us to know what is going on with your health. Please be thorough when filling out these forms.

What's in the forms:

The first page is a form to gather general demographic data and your immediate health concerns. The second page gathers detailed information regarding your current complaints and general health questions. Please fill out the portions that pertain to you. If you need more space, please use the 4th page to add any information.

Additional wellness Form:

On our website: <http://familywellnesssolution.com/office.html> you will find an additional form called wellness questionnaire. If you would like us to evaluate your lifestyle, please fill it out also.

Filling out the forms:

You have the option to fill the forms out on your computer and then print them out, or print the pages and fill them out by hand. Either way, please remember to bring them in with you.

Questions:

If you have questions regarding the forms, just leave that portion of the form blank and we can fill it together during your visit. For any other questions, please do not hesitate to call us at (804)594-1998.

We look forward to seeing you.

Sincerely,

Chiropractic & Family Wellness PC



CHIROPRACTIC & FAMILY WELLNESS PC
— GUIDING YOUR FAMILY TO WELLNESS —



Patient Introduction Card

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell: (____) _____ Date of Birth: ____ / ____ / ____ Age: _____

Married Single Divorced Name of Spouse: _____

Name of Children: _____

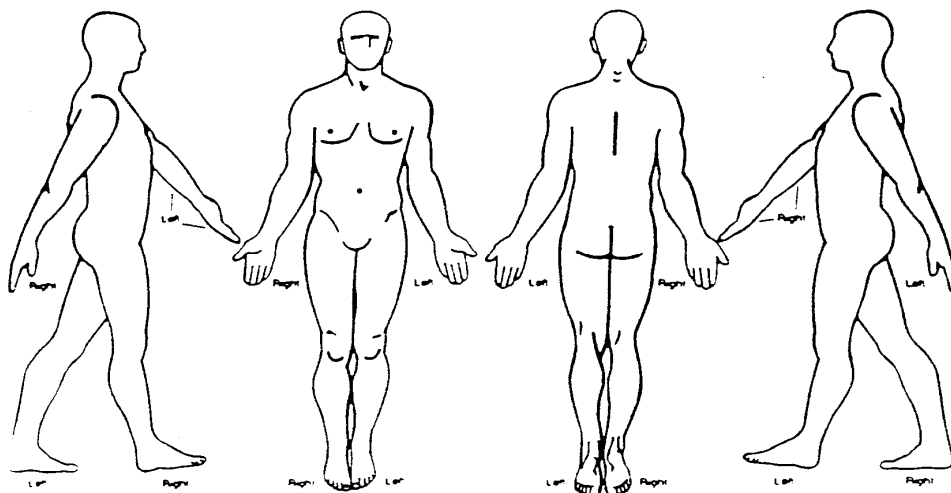
Type of work: _____ Work Phone: (____) _____

Insurance company: _____ (Please give our Chiropractic Assistant your insurance card.)

Referred by: _____ Have you had chiropractic care before? _____

Who is your Doctor? _____ Phone: (____) _____

Outline area(s) where you have pain or other symptoms:



Please **circle** areas of pain and indicate what you have been feeling by using:

P (dull/ache pain)

S (sharp/stabbing pain)

B (burning pain)

N (numbness)

T (tingling).

When and How did the complaints you have now start: _____

Please describe previous treatments: _____

What is your pain **RIGHT NOW**?

No pain: _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL or AVERAGE pain**? (over the last week)

No pain: _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What is your pain level **AT ITS WORST** (How close to 10 does it get at its worst)?

No pain: _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

How often do you have this complaint?

(0 % - 25 %) Infrequent

(26 % - 50 %) Often

(51 % - 75 %) Very often

(76 % - 100 %) All the time / constant

What makes your complaints better & worse? _____

Condition's Effect On:
Job Performance

No Effect

Mod to Sev Limited Duty

Mild (Painful but can do duties)

Severe (No Limited Duty)

Moderate (Painful limited ability)

Severe (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Care – Infirm Family:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Carrying Groceries:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Change from Sit to Stand:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Climb Stairs:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Driving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Extended Computer Use:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Household Chores:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Kneeling:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Lifting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Pet Care:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Reading(Concentration):	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Self Care–Bathing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Self Care–Dressing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Self Care–Shaving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Sexual Activities:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Sleep:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Static Sitting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Static Standing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Walking:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Yard Work:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform

List Serious Injuries, Illnesses, Surgeries & Fractures _____

Medications _____

Review of Systems: (check all that applies)

- Swelling/Stiffness of joints
- Arthritis
- Numbness/Tingling
- Muscle twitching
- Dizziness/fainting
- Convulsions
- Headaches
- Stroke
- Depression
- Heart condition

Height: _____

- Shortness of breath
- High blood pressure
- Excessive weight loss/gain
- Constipation/Diarrhea
- Control of Bowels
- Control of bladder
- Kidney/Bladder condition
- Frequent urination
- Diabetes
- Heart burn

Weight: _____

- Stomach condition
- Allergies/Asthma
- Respiratory condition
- Sinus condition
- Cancer
- Breast soreness/lump
- Condition of uterus
- Menstrual problems
- Sexual dysfunction

Family History:

- | | | |
|-----------------------------------|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid Arthritis |
| | <input type="checkbox"/> Heart Problems / Stroke | |

I certify this information to be true and accurate and I will notify you of any changes in my (or my child's) health status or any of the above. I also authorize the release of any medical or other information necessary to process insurance claims. I authorize and request the insurance company to pay directly to the clinic the insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand that, regardless of the insurance status, I am always responsible for the charges for services rendered to me (or my child) at this clinic. I acknowledge and agree to be responsible to Chiropractic & Family Wellness PC for any cost incurred in collecting unpaid balances or checks that are denied due to insufficient funds, stop payments or any other reason. A service charge of \$35.00 will be charged for any check upon which payment is denied. I also certify that I received a Notice of Chiropractic & Family Wellness PC Privacy Practices.

Signature of patient or Guardian: _____ Date: _____

Would you like to sign up for our newsletter: Yes

I herby affirm that I am the parent or guardian, who is legally allowed to make medical decisions on behalf of this minor. I herby authorize this office and its Doctor(s) to administer care as they so deem necessary to my Son/Daughter/Ward.

Signature of patient or Guardian: _____ Date: _____

