Dominion Chiropractic Clinic

Patient Name:_____ Date_____

Cell Phone _____ Home Phone _____ Work Phone_____

Address _____ City_____ State_____ Zip_____

Email Address_____

Sex ☐M ☐F Marital Status ☐M ☐S ☐D ☐W Date of Birth_____ Age _____

Social Security Number_____

Occupation_____

Employer _____

Referred by_____

Have you ever received chiropractic care? ☐Yes ☐No If yes, when? _____

Name of most recent chiropractor? _____

Reasons for seeking chiropractic care:

Primary reason _____

Secondary reason_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____

_____

Primary Care Physician _____

Social and Occupational History

Job Description_____

Work Schedule_____

Recreational Activities_____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet)

_____

3904 Meadowdale Blvd
N Chesterfield, VA 23234
dominionchiro@gmail.com

(o) 804-271-7920
(f) 804-271-8538

Dominion Chiropractic Clinic
Review of Systems Name _____ Date _____

Have you had any of the following **pulmonary (lung-related)** issues?
☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐Other _____ ☐ N/A

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs ☐ Heart disease/problems
☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat ☐ Other _____ ☐ N/A

Have you had any of the following **neurological (nerve-related)** issues?
☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell ☐ Strokes/TIAs ☐ Other _____ ☐ N/A

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes ☐ Other _____ ☐ N/A

Have you had any of the following **renal (kidney-related)** issues or procedures?
☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder infections ☐ Difficulty urinating
☐ Kidney disease ☐ Dialysis ☐ Other_____ ☐ N/A

Have you had any of the following **gastroenterological (stomach-related)** issues?
☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation ☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools ☐ Vomiting blood ☐ Bowel incontinence
☐ Gastroesophageal reflux/heartburn ☐ Other _____ ☐ N/A

Have you had any of the following **hematological (blood related)** issues?
☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV positive ☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia ☐ Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use ☐ Other _____ ☐ N/A

Have you had any of the following **dermatological (skin-related)** issues?
☐ Significant burns ☐Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other_____ ☐ N/A

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken Bones ☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery
☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal Implants ☐Other _____ ☐ N/A

Have you had any of the following **psychological** issues?
☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐Bipolar disorder ☐Homicidal ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other _____ ☐ N/A

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dominion Chiropractic Clinic for services performed. I also understand that I am personally responsible for any and all charges which are incurred as a result of my care at this office.

Patient/Guardian signature _____ Date_____

3904 Meadowdale Blvd
N Chesterfield, VA 23234
dominionchiro@gmail.com

(o) 804-271-7920
(f) 804-271-8538

Dominion Chiropractic Clinic

Name_____ DOB_____

In the past 5 years:

Major Illnesses_____

Surgeries/Date of procedure(s) _____

Hospitalization/Date_____

Allergies_____

Current medications (dosage and frequency)

_____

_____

_____

Previous injury, trauma, or auto accidents

_____

_____

Any broken bones_____

FAMILY HISTORY	Major Illnesses	Date of Death	Cause
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
SIBLINGS	_____	_____	_____
	_____	_____	_____

Smoking Status ☐ Non-smoker ☐Current smoker ☐Former smoker

Alcohol Use ☐None ☐Casual ☐Moderate ☐Heavy ☐Drinks beer ☐Drinks wine

Recreational Drug Use ☐None ☐Recreational ☐Addiction

Caffeine Intake ☐ None ☐<3 drinks/day ☐3-6 drinks/day ☐>6 drinks/day

Exercise ☐Never ☐Daily ☐Weekly ☐Walks ☐Runs ☐Swims

Race_____ Ethnicity_____ Language_____

Signature_____ Date_____

3904 Meadowdale Blvd
N Chesterfield, VA 23234
dominionchiro@gmail.com
(o) 804-271-7920
(f) 804-271-8538

Dominion Chiropractic Clinic
Patient Name _____ Date_____

New Patient History Form

Please list your primary complaint for symptom 1. If you have a secondary complaint to address, use symptom 2.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin ☐suddenly or ☐gradually?
  - How did the symptom begin? _____
- What makes the symptom worse?☐Bending neck forward ☐bending neck backward ☐tilting head to left ☐tilting head to right ☐turning head to left ☐turning head to right ☐bending forward at waist ☐bending backward at waist ☐tilting left at waist ☐tilting right at waist ☐twisting left at waist ☐twisting right at waist ☐sitting ☐standing ☐getting up from seated position ☐lifting ☐any movement ☐driving ☐walking ☐running ☐nothing ☐other _____
- What makes the symptom better? ☐rest ☐ice ☐heat ☐stretching ☐exercise ☐massage ☐pain medication ☐muscle relaxers ☐nothing ☐ other _____
- Describe the quality of the symptom: ☐sharp ☐dull ☐achy ☐burning ☐throbbing ☐piercing ☐stabbing ☐deep ☐nagging ☐shooting ☐ stinging ☐other _____
- Does the symptom radiate to another part of your body? ☐No ☐Yes If yes, where _____
- Is the symptom worse at certain times of the day or night? ☐morning ☐afternoon ☐evening ☐night ☐unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin ☐suddenly or ☐gradually?
  - How did the symptom begin? _____
- What makes the symptom worse?☐Bending neck forward ☐bending neck backward ☐tilting head to left ☐tilting head to right ☐turning head to left ☐turning head to right ☐bending forward at waist ☐bending backward at waist ☐tilting left at waist ☐tilting right at waist ☐twisting left at waist ☐twisting right at waist ☐sitting ☐standing ☐getting up from seated position ☐lifting ☐any movement ☐driving ☐walking ☐running ☐nothing ☐other _____
- What makes the symptom better? ☐rest ☐ice ☐heat ☐stretching ☐exercise ☐massage ☐pain medication ☐muscle relaxers ☐nothing ☐ other _____
- Describe the quality of the symptom: ☐sharp ☐dull ☐achy ☐burning ☐throbbing ☐piercing ☐stabbing ☐deep ☐nagging ☐shooting ☐ stinging ☐other _____
- Does the symptom radiate to another part of your body? ☐No ☐Yes If yes, where _____
- Is the symptom worse at certain times of the day or night? ☐morning ☐afternoon ☐evening ☐night ☐unaffected by time of day

3904 Meadowdale Blvd
N Chesterfield, VA 23234
dominionchiro@gmail.com

(o) 804-271-7920
(f) 804-271-8538

Dominion Chiropractic Clinic

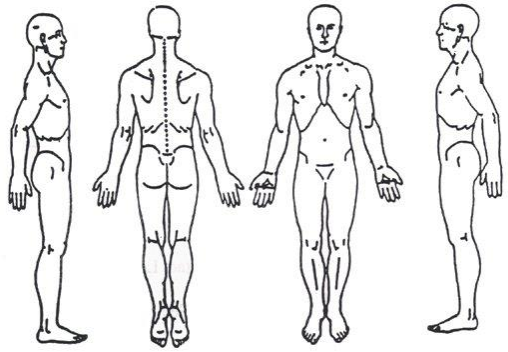
Name _____ Date_____

Functional Rating Index

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1.	**Pain Intensity**	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
2.	**Sleeping**	0 Perfect sleep	1 Mildly disturbed sleep	2 Moderately disturbed sleep	3 Greatly disturbed sleep	4 Totally disturbed sleep
3.	**Personal Care** (washing, dressing, etc)	0 No pain; no restrictions	1 Mild pain; no restrictions	2 Moderate pain; need to go slowly	3 Moderate pain; need some assistance	4 Severe pain; need 100% assistance
4.	**Travel** (driving, etc)	0 No pain on long trips	1 Mild pain on long trips	2 Moderate pain on long trips	3 Moderate pain on short trips	4 Severe pain on short trips
5.	**Work**	0 Can do usual work plus unlimited extra work	1 Can do usual work with no extra work	2 Can do 50% of usual work	3 Can do 25% of usual work	4 Cannot work
6.	**Recreation**	0 Can do all activities	1 Can do most activities	2 Can do some activities	3 Can do a few activities	4 Cannot do any activities
7.	**Frequency of pain**	0 No pain	1 Occasional pain 25% of the day	2 Intermittent pain 50% of the day	3 Frequent pain 75% of the day	4 Constant pain 100% of the day
8.	**Lifting**	0 No pain with heavy weight	1 Increased pain with heavy weight	2 Increased pain with moderate weight	3 Increased pain with light weight	4 Increased pain with any weight
9.	**Walking**	0 No pain any distance	1 Increased pain after 1 mile	2 Increased pain after ½ mile	3 Increased pain after ¼ mile	4 Increased pain with all walking
10.	**Standing**	0 No pain after several hours	1 Increased pain after several hours	2 Increased pain after 1 hour	3 Increased pain after ½ hour	4 Increased pain with any standing

Patient's signature_____ Date_____



Please indicate problem areas on the chart

(pain- XXX, numbness- NNN, tingling- TTT)

3904 Meadowdale Blvd
N Chesterfield, VA 23234
dominionchiro@gmail.com

(o) 804-271-7920
(f) 804-271-8538