Optimal Chiro – Rehab Center

New Patient Health History Form

8303 Arlington Blvd., Suite 202 Fairfax, VA 22031
P: 703-573-4773 F: 703-573-2552 E: info@oc-rc.com

Today's date:	PCP:

PATIENT INFORMATION

LAST NAME:	FIRST:	M.I.	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Wid / Sep /

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:			Social Security no.: - -	Home phone no.: ( )
City:	State:	ZIP Code:		Cell phone no.: ( )
Occupation:	Employer:			Work phone no.: ( )

Email address:

Spouse's name:	Spouse's occupation:	Spouse's employer:

Referred to clinic by (please check one and specify):

❑ Dr.: ❑ Close to home/work:

❑ Family member: ❑ Other:

❑ Friend: Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone No. : ( )

INSURANCE INFORMATION

Name of Insurance Company:	
Name as it is written on card:	Date of Birth:
Membership ID Number:	
Group Number:	
Enrollment Code (if applicable):	
Provider/Claims Phone Number (back of card):	

Are you the Policy Holder? ❑Yes ❑No	If **NO**, Name of Policy Holder:	Policy Holder's Date of Birth:

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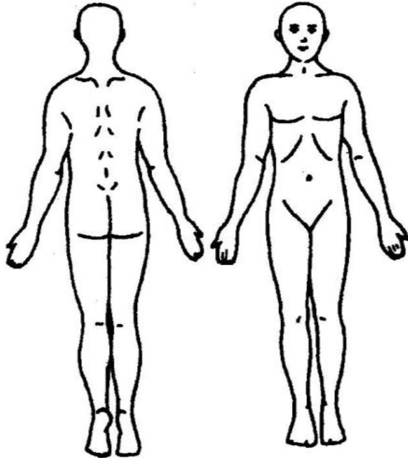
PATIENT CHIEF COMPLAINTS

Please mark the location of your pain.



Please list your current symptoms and on a scale of 0 – 10 (with 0 being no pain and 10 being the worst) how would you rate your pain?

Complaint 1: ______________________Date it began:__________

0 1 2 3 4 5 6 7 8 9 10

Complaint 2: ______________________Date it began___________

0 1 2 3 4 5 6 7 8 9 10

Complaint 3: ______________________Date it began:__________

0 1 2 3 4 5 6 7 8 9 10

Complaint 4: ______________________Date it began:__________

0 1 2 3 4 5 6 7 8 9 10

Have you seen any other physicians for any of the above condition(s)? ❑Yes ❑No

If YES, please explain:

Have you ever been under chiropractic care? ❑Yes ❑No	When? How long were you treated?

Medications you are currently taking for your condition(s) (please list) :

Do you experience pain every day?	❑YES ❑NO
Do your symptoms interfere with everyday life?	❑YES ❑NO
Does pain wake you up at night?	❑YES ❑NO
Are your symptoms worse during certain times of the day?	❑YES ❑NO
Do changes in weather affect your symptoms?	❑YES ❑NO
Do you wear orthotics?	❑YES ❑NO

ACTIVITIES OF DAILY LIVING

Please list any work related, personal, and/or recreational activities that are affected by your condition:

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PAST MEDICAL HISTORY

Have you been treated for any conditions this last year? ❑Yes ❑No	If yes, please describe:		
Date of last physical exam: / /	Women: Have you ever been pregnant? ❑Yes ❑No	Have you had x-rays taken? ❑Yes ❑No	If so, where:

Please circle any conditions you have or have had:

Allergies	Cold extremities	Frequent urination	Loss of smell	Prostate trouble
Anemia	Constipation	Headache/migraines	Loss of taste	Sciatica
Arteriosclerosis	Chicken Pox	Hemorrhoids	Lumps in breast	Scoliosis
Arthritis	Depression	Hot flashes	Mental disorders	Shortness of breath
Asthma	Diabetes	High blood pressure	Mumps	Sleep problems/insomnia
Back pain	Digestion Problems	Influenza	Neck pain or stiffness	Spinal curvatures
Bronchitis	Dizziness	Irregular heart beat	Nervousness	Stroke
Bruise easily	Eczema	Kidney infection	Pacemaker	Swollen joints
Cancer	Epilepsy	Kidney stones	Pleurisy	Thyroid condition
Chest pain/conditions	Eye Pain/difficulties	Loss of balance	Polio	Tuberculosis
Cramps	Fatigue	Loss of memory	Pneumonia	Ulcers

For women only:
Date of last period: _____________ Are you pregnant? ❑Yes ❑No

Are there any other conditions we should be aware of? ____

Have you ever:		Explanation/Dates of Treatment
Broken bones?	❑NO ❑YES	
Any previous auto accidents?	❑NO ❑YES	
Previous sprains/strains?	❑NO ❑YES	

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○

The information provided above was completed correctly and is true to the best of my knowledge. I understand it is my responsibility to inform the office of any changes to the information I have provided. I authorize Optimal Chiro-Rehab Center to treat my condition as they deem appropriate and to perform any necessary services needed during diagnoses and treatment.

Signature of patient or legal guardian: ________________________________

Date: ________________________________