

# CIRCLE CHIROPRACTIC CENTER, P.C. - Dr. Christopher Frey

9526 B Lee Highway, Fairfax, VA 22031 Phone: 703-385-2990 FAX: 703-385-1657 CircleChiropracticCenter.com

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Residence and mailing City State Zip Code

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Email Address: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation/Employer's Name and address: \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Spouse's Occupation/Employer \_\_\_\_\_

Names & Ages of Children: \_\_\_\_\_

Reason for consulting our office: \_\_\_\_\_

Whom may we Thank for referring you to our office? \_\_\_\_\_

## Your Health Profile

### Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

### The Beginning Years (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

### Your Childhood Years

	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Comments: \_\_\_\_\_

### Adult (18 to present)

	YES	NO		YES	NO
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1-10, describe your stress level: (1 = none / 10 = extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____		
			Personal _____		

On a scale of Poor, Good, Excellent describe your:

Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

## Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here \_\_\_ **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”** Others need to briefly describe the chief area of complaint, including the **effect it has had on your life.**

If you are experiencing pain, is it . . .

Sharp     Dull     Comes and Goes     Travels     Constant

Since the problem started, it is . . .     About the Same     Getting Better     Getting Worse

What makes it worse: \_\_\_\_\_

Yes, it interferes with:     Work     Sleep     Walking     Sitting     Hobbies     Leisure

Other doctors seen for this problem (please list)

Chiropractor \_\_\_\_\_

Medical Doctor \_\_\_\_\_

Other \_\_\_\_\_

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back pain              | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping Problems        | <input type="checkbox"/> Neck stiff               | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Cold sweats              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Problems urinating     | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Menstrual pain           | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers          |

List any medications you are taking \_\_\_\_\_

### Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children \_\_\_\_\_

Spouse \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Others \_\_\_\_\_

Have you ever:

Bought bottled water:                     YES                     NO

Belonged to a health club                     YES                     NO

Consumed vitamins or supplements:                     YES                     NO

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# CIRCLE CHIROPRACTIC CENTER, P.C.

PRO-ACTIVE FAMILY HEALTH CARE FROM THE INSIDE OUT

DR. CHRISTOPHER FREY  
9526 B LEE HIGHWAY  
FAIRFAX, VIRGINIA 22031  
(703) 385-2990  
FAX (703) 385-1657  
EMAIL-FREYCHIRO@AOL.COM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 2 WEEKS:**

**Musculo-Skeletal Code**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Arm Pain             | <input type="checkbox"/> Difficult Chewing |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Clicking Jaw      |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Walking Problems     | <input type="checkbox"/> General Stiffness |

**Nervous System Code**

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Forgetfulness        | <input type="checkbox"/> Cold/Tingling Extremities |
| <input type="checkbox"/> Numbness    | <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Stress                    |
| <input type="checkbox"/> Paralysis   | <input type="checkbox"/> Fainting             |  |
| <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Convulsions          |  |

**General Code**

- |                                    |  |                                    |
|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Fatigue   | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fever         |                                    |

**Gastro-Intestinal Code**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Abdominal Cramps         |
| <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> Hemorrhoids           | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Frequent Nausea         | <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Heartburn                |
| <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Black/Bloody Stool       |
| <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Weight Trouble        |   |

**Genito-Urinary Code**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Painful/Excessive Urination | <input type="checkbox"/> Discolored Urine |
|--|--|---|

**C-V-R Code**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Irregular Heartbeat      | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Lung Problems/Congestion | <input type="checkbox"/> Stroke         |

**EENT Code**

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Earaches    | <input type="checkbox"/> Stuffed Nose       |

**Male/Female Code**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Vaginal Pain/Infection | <input type="checkbox"/> Prostrate/Sexual Dysfunction |
| <input type="checkbox"/> Menstrual Cramps       | <input type="checkbox"/> Breast Pain/Lumps      |   |

**Other**

- |                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

**How Do You Rate Yourself?  
(Circle Your Answer)**

**NUTRITION (Weight)**

- Poor  
Fair  
Good  
Excellent

**EXERCISE (Fitness)**

- Poor  
Fair  
Good  
Excellent

**SLEEP (Energy)**

- Poor  
Fair  
Good  
Excellent

**STRESS**

- |                |            |
|----------------|------------|
| (Occupational) | (Personal) |
| None           | None       |
| Mild           | Mild       |
| Moderate       | Moderate   |
| Severe         | Severe     |

**FEMALES ONLY**

When was your last period? \_\_\_\_\_

Are you pregnant?  Yes  No  Not Sure

**PLEASE TURN OVER**

**THIS FORM CONTINUES**

**ON REVERSE SIDE**

## REVISED OSWESTRY CHRONIC PAIN DISABILITY QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW**

### SECTION 1 - Pain Intensity

- A The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate.
- D The pain is moderate and does not vary much.
- E The pain comes and goes and is severe.
- F The pain is severe and does not vary much.

### SECTION 6 - Standing

- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than 1/2 hour without increasing pain.
- E I cannot stand for longer than ten minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away.

### SECTION 2 - Personal Care

- A I do not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increases the pain but I manage not to change my way of doing it.
- D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E Because of the pain, I am unable to do some washing and dressing without help.
- F Because of the pain, I am unable to do any washing and dressing without help.

### SECTION 7 - Sleeping

- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D Because of pain, my normal night's sleep is reduced by less than one-half.
- E Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F Pain prevents me from sleeping at all.

### SECTION 3 - Lifting

- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it causes extra pain.
- C Pain prevents me from lifting heavy weights off the floor.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F I can only lift very light weights, at the most.

### SECTION 8 - Social Life

- A My social life is normal and gives me no pain.
- B My social life is normal, but increases the degree of my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D Pain has restricted my social life and I do not go out very often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of the pain.

### SECTION 4 - Walking

- A Pain does not prevent me from walking any distance.
- B Pain prevents me from walking more than one mile.
- C Pain prevents me from walking more than 1/2 mile.
- D Pain prevents me from walking more than 1/4 mile.
- E I can only walk while using a cane or on crutches.
- F I am in bed most of the time and have to crawl

### SECTION 9 - Travel

- A I get no pain while traveling.
- B I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D I get extra pain while traveling, which compels me to seek alternative forms of travel.
- E Pain restricts all forms of travel.
- F Pain prevents all forms of travel except that done lying down.

### SECTION 5 - Sitting

- A I can sit in any chair as long as I like without pain.
- B I can only sit in my favorite chair as long as I like.
- C Pain prevents me from sitting more than one hour.
- D Pain prevents me from sitting more than 1/2 hour.
- E Pain prevents me from sitting more than ten minutes.
- F Pain prevents me from sitting at all.

### SECTION 10 - Changing degree of pain

- A My pain is rapidly getting better.
- B My pain fluctuates but overall is definitely getting better.
- C My pain seems to be getting better but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

Revised 9/11/1992 From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_