

Circle Chiropractic Center

9526-B Lee Hwy / Fairfax, VA 22031

www.circlechiropracticcenter.com

PHONE: (703) 385 - 2990 FAX (703) 385 - 1657

NAME _____ DATE OF BIRTH _____ AGE _____

HOME ADDRESS _____
Street City State Zip Code

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ JOB TITLE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

SEX M F SSN _____ SPECIAL NEEDS _____

MARITAL STATUS MARRIED SINGLE DIVORCED WIDOW(ER) PARTNER

NAME OF SPOUSE OR PARENT _____ HOME NUMBER _____
ADDRESS (IF DIFFERENT) _____ WORK NUMBER _____

NAMES AND AGES OF CHILDREN _____

EMERGENCY CONTACT _____
Name Relationship Phone Number

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 _____

If, however, you are experiencing pain please answer the following questions:

PLEASE BRIEFLY DESCRIBE THE CHIEF AREA OF COMPLAINT, INCLUDING THE EFFECT IT HAS HAD ON YOUR LIFE:

For the questions below, please circle all that apply.

If you are experiencing pain it is: SHARP DULL COMES & GOES TRAVELS CONSTANT

It interferes with:

Since the problem started it is: GETTER BETTER GETTING WORSE ABOUT THE SAME

WORK SLEEP WALKING SITTING HOBBIES

What makes the problem worse? _____

What makes the problem better? _____

Other Doctors seen for this problem (please list):

Chiropractors _____ Phone _____
Medical Doctors _____ Phone _____
Other _____ Phone _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

OTHER INFORMATION YOU'D LIKE TO SHARE WITH US:

PATIENT SIGNATURE

Patient Signature

DATE

Parent/Guardian or Spouse's Signature

DATE

Circle Chiropractic Center

YOUR HEALTH PROFILE

Why Is This 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 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.

THE BEGINNING YEARS (BIRTH TO AGE 17)	Details
Did you have any childhood illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Did you have any serious falls as a child?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Did you play youth sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Did you take/use any drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Did you have any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Have you fallen/jumped from a height over three feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Were you involved in any car accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Were you vaccinated?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
As a child, were you under regular Chiropractic care?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

ADULT YEARS (18 TO PRESENT)	
Do/did you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No Past Current _____cigarettes a day / week / month (circle)
Do/did you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No Past Current _____drinks a day / week / month (circle)
Have you been in any accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____
Have you had any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____
Do/did you play any adult sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____
Do/did you participate in extreme sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____
On a scale of 1-10 describe your stress level (1=none / 10=extreme):	Occupational _____ Personal _____
On a scale of Poor, Good, Excellent, please describe your:	Diet _____ Exercise _____ Sleep _____ Concentration _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being but also in 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 _____

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.

Patient/Guardian Signature

Date

Pro-Active Family Healthcare

From The Inside Out!

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www.circlechiropracticcenter.com
circlechiro@gmail.com

Please fill out forms fully and completely. Don't forget to sign all signature blocks. Thank you!

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"/> _____ |

FEMALES ONLY

When was your last period? _____
 Are you pregnant? Yes No Not Sure

How Do You Rate Yourself?
(Circle Your Answer)

NUTRITION (Weight)
 Circle One
 Poor Fair Good Excellent
 Please List Any Supplements: _____

EXERCISE (Fitness)
 Circle One
 Poor Fair Good Excellent
 What Type? _____

SLEEP (Energy)
 Circle One
 Poor Fair Good Excellent
 Details: _____

STRESS
 (Occupational) (Personal)
 None Mild Moderate Severe
 Circle One
 None Mild Moderate Severe

Additional Notes:

REVISED OSWESTRY CHRONIC PAIN DISABILITY QUESTIONNAIRE

PLEASE CIRCLE ONLY ~ONE~ ANSWER. PLEASE ANSWER EVERY SINGLE QUESTION.

PAIN INTENSITY - General

- 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.

LIFTING - General

- A I can lift heavy weight 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 (ex. 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.

SOCIAL LIFE / RECREATION - General

- A My social life is normal and gives me no pain.
- B My social life is normal, but increases the degree of pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests (ex. 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.

HEADACHES - Neck

- A I have no headaches at all.
- B I have slight headaches, which come infrequently.
- C I have moderate headaches, which come infrequently.
- D I have moderate headaches, which come frequently.
- E I have severe headaches, which come frequently.
- F I have headaches almost all the time.

READING - Neck

- A I can read as much as I want with no pain in my neck.
- B I can read as much as I want with a slight pain in my neck.
- C I can read as much as I want with moderate pain in my neck.
- D I can't read as much as I want because of moderate pain in my neck.
- E I can hardly read at all because of severe pain in my neck.
- F I cannot read at all because of severe pain in my neck.

CONCENTRATION - Neck

- A I can concentrate fully when I want with no difficulty.
- B I can concentrate fully when I want with slight difficulty.
- C I have a fair degree of difficulty in concentrating when I want.
- D I have a lot of difficulty in concentrating when I want.
- E I have a great deal of difficulty in concentrating when I want.
- F I cannot concentrate at all.

WORK - Neck

- A I can do as much work as I want.
- B I can only do my usual work, but no more.
- C I can do most of my usual work, but no more.
- D I cannot do my usual work.
- E I can hardly do any work at all.
- F I can't do any work at all.

CHANGING DEGREE OF PAIN - All pain

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

PERSONAL CARE - General

- 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 or dressing without help.

SLEEPING - General

- 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.

WALKING - Back

- 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.

SITTING - Back

- 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'd 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.

STANDING - Back

- 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 more than one hour without increasing pain.
- D I cannot stand for more than 1/2 hour without increasing pain.
- E I cannot stand for more than ten minutes without increasing pain.
- F I avoid standing because it increases pain right away.

TRAVEL - Back

- A I get no pain while traveling.
- B I get some pain while traveling but none of my usual forms of travel makes it 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 restricts all forms of travel except that done lying down.

DRIVING - Neck

- A I can drive my car without any neck pain.
- B I can drive my car as long as I want with slight pain in my neck.
- C I can drive my car as long as I want with moderate pain in my neck.
- D I can't drive my car as long as I want because of moderate pain in my neck.
- E I can hardly drive at all because of severe pain in my neck.
- F I cannot drive my car at all.

Patient Signature _____

Date _____