WHERE WORK GETS DONE.

Achieve Chiropractic

11721 Jefferson Ave
Newport News, VA 23606
757-224-9223, Fax 757-224-9293

Please Print Clearly

First Name: _________________________ M. I.: _____ Last Name:______________________________________

Age: _____ BOD: ____ /____ /____ Circle: Male / Female Circle: Single / Married Height: _____Weight: _______

Address: _________________________________City:_____________________ State: ____________ Zip: ______

Email :____@____________________________________

Preferred Phone: _________________________ Work Phone: ____________________ Other: ____________________

Employer: ____ Occupation: ______________________

Emergency Contact: ______________________________Emergency Contact Phone Number: ______________________

How did you hear about us?____

How do you rate your present health? ____

Do you exercise? Yes / No Hrs. per week ___________What activity(s)?______________________________________

Are you pregnant? Yes / No If yes, how many weeks? _______________________

List any surgeries or hospitalizations pertaining to your complaint: ____
____

Are you here because of an accident? ___YES ___NO If yes, please explain:
____

Have you received treatment for these symptoms? _____ Yes _ No If yes, when and with whom was your last visit?
____

Primary care physician: _____________________________________Date last seen: _____________________________

Location: ____Phone: ______________________________

Print Patient Name:____Date:_____________________________

Patient Signature:____

Parent/ LegalGuardian:____

Doctor's Initials:_______

Describe the **main complaint**:____

How did your symptom start? Approximately when?______________________________

Have you experienced this symptom in the past? ______________________________

On a scale of 1-10, with 10 being most severe, circle your level of discomfort: 1 2 3 4 5 6 7 8 9 10

Describe your symptom? (Circle all that apply)

Sharp Dull-Ache Numbing Burning Tingling Shooting Stiff Stabbing Throbbing Other__________________

How would you rate the Intensity of discomfort? (Circle one) Mild Moderate Severe

How often do you experience this symptom? (Circle one) Constantly Frequently Occasionally Intermittently

Since the onset of discomfort, is your symptom? (Circle one) Getting better Staying the same Getting worse

Does the discomfort radiate or travel? _________ If yes, please describe where: ______________________

What helps to improve your complaint? (Circle all that apply) Rest Cold Pack Heat Stretching Exercise Massage

OTC Medication Prescription Medicine Other: ____________________________________

Describe **additional complaint**:____

How did your symptom start? Approximately when?______________________________

Have you experienced this symptom in the past? ______________________________

On a scale of 1-10, with 10 being most severe, circle your level of discomfort: 1 2 3 4 5 6 7 8 9 10

Describe your symptom? (Circle all that apply)

Sharp Dull-Ache Numbing Burning Tingling Shooting Stiff Stabbing Throbbing Other________________

How would you rate the Intensity of discomfort? (Circle one) Mild Moderate Severe

How often do you experience this symptom? (Circle one) Constantly Frequently Occasionally Intermittently

Since the onset of discomfort, is your symptom? (Circle one) Getting better Staying the same Getting worse

Does the discomfort radiate or travel? _________ If yes, please describe where: ______________________

What helps to improve your complaint? (Circle all that apply) Rest Cold Pack Heat Stretching Exercise Massage

Doctor's Notes

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