Mountain Spring Chiropractic Center
1569 Jefferson Highway Suite 105
Fishersville, Virginia 22939

APPLICATION FOR TREATMENT Date _____

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____/___/_____
Address: _____
Street Number City/State/Zip Code
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____
Contact Preference: ☐ Home ☐ Cell ☐ Work ☐ Email
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed
Race: ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ White/Caucasian ☐ American Indian/Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other _____
Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Disabled ☐ Unemployed
Employer:_____ Phone #_____
Emergency Contact: _____
Name Phone Number Relationship
Were you referred to us? ☐ Yes ☐ No By Who? _____

GENERAL HEALTH HISTORY

Have you been treated by a Chiropractor before? ☐ Yes ☐ No
If yes, whom did you see and for what? _____
_____
Have you been treated by a Physician for any health condition in the last year? ☐ Yes ☐ No
If yes, whom did you see and for what? _____
_____
Are you pregnant? ☐ Yes ☐ No If yes, when is your due date: _____
Are you a smoker? ☐ Yes ☐ No If yes, how many per day: _____
Consume alcohol? ☐ Yes ☐ No If yes, how much per day: _____
Have you ever been in an automobile accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years

MEDICATIONS

NAME	DOSAGE	FREQUENCY	START DATE

(rev. 11/16)

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Patient Name _____ Date _____

ALLERGIES (Environmental, Food, Medicinal) **PLEASE list reaction, if possible

_____

_____

_____

CURRENT COMPLAINT(S)

Chief Complaint: Please describe your complaint and how long it has been a problem.

Do you experience this pain every day? ☐ Yes ☐ No
Do your symptoms interfere with daily life? ☐ Yes ☐ No
Does this pain wake you up at night? ☐ Yes ☐ No
Do changes in weather affect you symptoms? ☐ Yes ☐ No
Do you wear orthotics? ☐ Yes ☐ No
Are your symptoms worse during: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night
Are they worse when you: ☐ Cough ☐ Sneeze ☐ Laugh ☐ Hiccup ☐ have a bowel movement

What activities aggravate your symptoms?

Do any activities provide relief? ☐ Yes ☐ No If Yes, please list

Habits	None	1-3/week	1-2/day	3+/day
Coffee	☐	☐	☐	☐
Caffeinated Beverages	☐	☐	☐	☐
Diet Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐
Water	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

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Patient Name _____ **Date** _____

SURGERIES: (Please list type of surgery and date of surgery)

_____
_____
_____
_____
_____
_____
_____
_____

TRAUMAS: (Please list falls, accidents)

_____
_____
_____
_____
_____
_____
_____
_____

WHAT DO YOU KNOW ABOUT YOUR BIRTH?

C-Section	□ Yes	□ No
Vaginal Delivery	□ Yes	□ No
Forceps	□ Yes	□ No
Vacuum	□ Yes	□ No
Breach	□ Yes	□ No
"Sunny Side Up"	□ Yes	□ No
Long labor	□ Yes	□ No
Premature	□ Yes	□ No

Other info you feel Dr. Elizabeth should know: _____
_____
_____
_____

What goals do you want help with?

_____
_____
_____
_____
_____

(rev. 11/16)