2402 Mt Vernon Ave.
Alexandria, VA 22301
703-299-0123

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Cell #:_____ Home #:_____ Work #:_____
(please ***circle*** the numbers at which we may leave a message)

Email Add:_____ Referred By:_____
(used for scheduling only, email is not suitable for handling treatment concerns)

Date of Birth:_____ Occupation:_____

Emergency Contact:_____ Ph#:_____

Are you presently under a physician or therapist's care:_____

What medications do you take:_____

What vitamins/supplements do you take: _____

Please list injuries, surgeries, or accidents:_____

Please list allergies:_____

Are you pregnant?_____(please let us know if your status changes)

What exercise do you do and how often:_____

Please briefly describe the reason for seeking treatment:

Health History: Please check if you have experienced:

(feel free to bring to our attention anything you would prefer to discuss rather than write).

___aneurysm/blood clots	____current skin infection	___scoliosis
___arthritis	____diabetes	___seizures
___asthma	____edema/swelling	___shoulder pain
___athlete's foot	____heart attack/disease	___ sinus issues
___fibromyalgia	____frequent headaches	___stroke
___tendonitis	____sudden weight loss	___hepatitis
___tingling in extremities	____bone/joint condition	____STD
___hi/lo blood pressure	____infection	___bursitis
___cancer/malignancies	____chest pain tightness	___paralysis
___constipation/diarrhea	____clinical depression	___HIV/AIDS
___torn cartilage/ligament	____TMJ/jaw tension	___hypoglycemia
___knee pain	____Multiple Sclerosis	___muscle spasms
___Tuberculosis	____varicose veins	___whip lash
___sleep disturbances	____sciatica	___anemia
___bleeding disorder	____back pain	___neck pain
___digestive problem	____bowel problems	___dizziness
___nervousness/irritability	____bladder problems	___weakness

When was your last medical exam and by whom:

Please rate your use of the following as heavy(***H***), moderate(***M***), light(***L***) or none(***N***):

__alcohol __water intake __diet soda __sweets __coffee __tea___fast food __regular soda __rec. drugs

Please comment about any significant health problems in your family (parents, children, siblings, spouse):

Is there anything else that we should know about you:

Payment is expected at time of treatment – Thank You. It is our pleasure to serve you.