DEL RAY Chiropractic & Massage
ALEXANDRIA, VA

2402 Mt Vernon Ave.
Alexandria, VA 22301
703.299.0123

Name: _____ *Date:* _____

Address: _____

City: _____ *State:* _____ *Zip code:* _____

Phone # _____ *Email:* _____

Date of Birth: _____ *Occupation:* _____

Emergency Contact: _____ *Phone #* _____

Referred By: _____

Please list all medications you are currently on or have recently taken: _____

_____

Please list all vitamins or other supplements you currently take: _____

_____

Please list any surgeries, major traumas (including concussions and broken bones), illnesses, recent immunizations, or other hospitalizations: _____

_____

Please list any allergies: _____

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

What types of exercise do you do and how often: _____

Please 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)

___aneurism/blood clots	___tingling in extremities	___scoliosis
___arthritis	___tuberculosis	___seizures
___fibromyalgia	___cancer/malignancies	___sinus issues
___tendonitis	___sleep disturbances	___stroke
___low blood pressure	___bleeding disorder	___hepatitis
___high blood pressure	___endocrine disorder	___TMJ/jaw tension
___constipation	___digestive problem	___bursitis
___diarrhea	___nervousness/irritability	___paralysis
___torn cartilage/ligament	___current skin infection	___HIV/AIDS
___foot/ankle pain	___diabetes	___muscle spasms
___knee pain	___heart attack/heart disease	___whip lash
___low back pain	___frequent headaches	___anemia
___mid/high back pain	___sudden weight loss	___dizziness
___neck pain	___bone/joint condition	___weakness
___shoulder pain	___infection	other:
___wrist/hand pain	___chest pain tightness	_____
___hip pain	___depression	_____

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

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 ___diet soda ___soda ___sweets ___coffee ___fast food ___cigarettes

Please comment on any significant health problems in your family: _____

_____

_____

_____

Is there anything else we should know about you? _____

_____

_____

_____

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