R. Peter Goodfield, D.C., P.C.
Goodfield Chiropractic Office
605 Old Brandy Road, Culpeper, VA 22701 540-825-8867

Patient Information

Date _____

Thank you for coming to our office for your health needs. Please complete this form in ink. (Please Print)

Name _____ Age_____ Date of Birth _____
First Middle Initial Last

Marital Status
Phone, Home (___)_____ Cell (___)_____Work (___)_____ M S D W

Address _____City _____State _____ Zip _____
E-mail _____ Occupation _____

Employer & Address _____City _____ State_____ Zip _____

Spouse or parent's name _____Employer_____ Work Phone (___)_____

Referred to us by (Please include person's name) Friend/Family _____ M.D / D.C. _____

Our Website _____ Add _____ Other _____

Emergency Contact Person _____ Phone (_____)_____

Hobbies / Pets_____

Insurance Information

__ Copy of Health Ins. Card
Is your visit related to an auto accident? _____ (If yes, please tell receptionist, so she can give you another form.)

Name of Ins. Company _____Name of Insured _____ Date of Birth _____

Do you have Additional Insurance? ___ No ___ Yes ___ Copy of Card Name of Insured _____ DOB_____

Visit is related to: ___Motor vehicle Accident ____Work related injury ____ Personal injury/slip and fall ___ Other

Name of retained attorney, if applicable _____ Address _____

Medical History

Previous Chiropractic Care ___ No ____ Yes Dr. _____
Name of family physician: Dr. _____ Known Allergies _____
List medications now taking_____
Are you pregnant? ____ Yes ____ No ____ Perhaps X-rays taken ___Yes ___No Where _____ Date _____
Do you have any metal implants? ____ Yes ____ No Where, what _____

Past Illnesses:

___ Arthritis ___Ulcer ___Cancer ___Diabetes ___HIV ____ High Blood Pressure
Surgeries (state year for each) _____

Family History:

___ Cancer ___Arthritis ___Osteoporosis ___Disk problems ___ Neck/Back surgery

Lifestyle Habits:

N = Never O= Occasional M = Moderately E =Excessively
___ Smoking ___ Alcohol ___Recreational Drugs ___Prescription Drugs ___Exercise

Responsible Party

___ Same as above Relationship to
Name of person responsible for this account? _____Patient _____Phone (____)_____
Address _____City _____ State _____Zip _____
Name of Employer _____ Work Phone (_____)_____
Patient's signature authorizing care: _____

Your Present Health Issue

Please describe your current problem, date it began and how it occurred:

_____
_____
_____
_____

List the doctors/dates seen for this condition, tests ordered, diagnosis, medications and therapies prescribed:

_____
_____
_____

The Character of your pain:

___ Sharp/stabbing ___Ache ___ Sore ___ Weak ___ Numb ___ Burning
___ Cramping ___ Throbbing ___ Pins/Needles ___ Tingling ___Shooting

Frequency of pain:

___ Constant ___ Frequent (50 - 75%) ___ Occasional (25 -50%) ___Intermittent (25% or less)

Intensity of pain:

(0= no pain 10= unbearable pain) 0 1 2 3 4 5 6 7 8 9 10 (please circle)

Pain is worse:

___ On Waking ___ Feet hit the floor ___ At work ___After work ___ First lay down ___ Sleeping
___ sitting ___ standing ___ walking ___ laying down

Progression of Pain:

___ Increasing ___ Decreasing ___ Not changing Last day worked _____

Type of work:

____ Heavy manual ___ Light manual ____ Much sitting

Stress Level:

____ Minimal ____ Moderate ___ Heavy

Pain drawing:

On the diagram, please Mark with precision:
Ache series of Os
Sharp catching pain series of Xs
Numbness and Tingling heavy dark line