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

Phone, Home (___)_____ Cell (___)_____Work (___)_____Marital Status 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

Name of Ins. Company _____Name of Insured _____
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 and how it occurred:

_____
_____
_____

Date it began_____/_____/_____ 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