Heneberry Chiropractic
627 N. Coalter St. Staunton, VA 24401
(540) 280-4539

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Preferred contact number: ☐ Home ☐ Cell ☐ Work

Email address: _____ May we use this to contact you? ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Type: ☐ Home ☐ Cell ☐ Work

How did you hear about us? ☐Referral from: _____

☐ Internet

☐ Other: _____

In your own words, please describe your symptoms/complaints:

How long have you had this/these condition(s)? _____

List any other doctors seen for this:

List any diagnosis and/or type of treatment:

Have you had similar accidents or injuries before? __ Yes __ No
If yes explain:

List the approximate dates of surgery for this/these condition(s):

Patient Name: _____ Date: _____

Does this condition limit your ability to do any of the following? (Circle all that apply)

Sitting	Standing	Laying
Bending	Lifting	Driving
Exercising	Walking	Other: _____

Have you received chiropractic treatment previously? __ Yes __ No

If yes, by whom: _____

When was your last adjustment? _____

Are you currently taking medication for this/these condition(s)? __ Yes __ No list medications:

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y/N When? _____

Is this condition interfering with Work? ____Sleep? _____ Routine? _____ Other? _____

Type of employment: _____

How many hours do you spend on the computer in an average week? _____

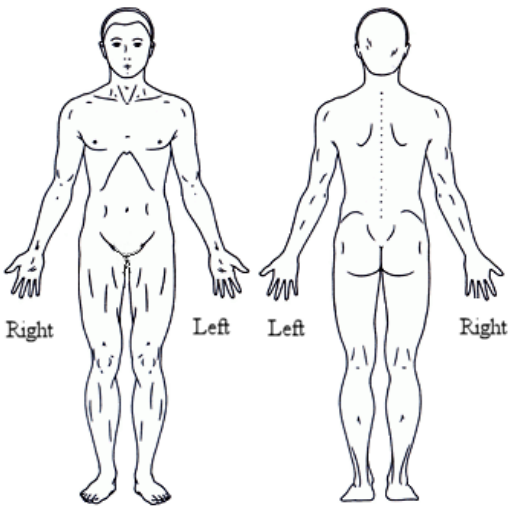
How many hours do you exercise per week? _____

What type of exercise? _____

What are your hobbies? _____

Using the symbols below, mark on the picture where you feel pain:

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



Circle your level of pain for each symptom/condition:

Neck/Upper Back Pain
0 1 2 3 4 5 6 7 8 9 10

Upper Extremity Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back/Hip Pain
0 1 2 3 4 5 6 7 8 9 10

Lower Extremity Pain
0 1 2 3 4 5 6 7 8 9 10

Medical Authorization
I authorize **Heneberry Chiropractic,** to release information regarding the above named patient to: (Name, telephone number, relationship to patient, example: mother, father, spouse, etc.,) **please note that ONLY THE NAME(S) LISTED** will be able to obtain medical information about you.

Name_____ Phone Number_____ Relationship_____
Name_____ Phone Number_____ Relationship_____
Name_____ Phone Number_____ Relationship_____

Informed Consent
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy by Dr. Rachel Heneberry. I have had an opportunity to discuss with Dr. Heneberry the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Payment Policy
All fees must be paid in full for all services rendered at the time of visit, unless PRIOR arrangements have been made. You are personally and fully responsible for all payments, regardless of whether or not we take insurance assignments. Returned checked will incur a $35 fee, and interest may be charged at 1.5% per month.

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____Date_____

Parent/Guardian
Signature _____ Date _____