



**2654 Valley Avenue, Suite E
Winchester, Virginia 22601
Phone 540.678.0100 Fax:540.678.1396**

To save time and allow us to better serve you, please complete all questions. Thank you!

<i>Name</i>			<i>Date of Birth</i>	
<i>Address (include city, state, & zip code)</i>			<i>Phone #</i>	
<i>Social Security #</i>	<i>Marital Status</i>	<i># of Children</i>	<i>Email</i>	
<i>Driver's License #</i>	S M D W			
<i>Occupation</i>	<i>Employer Name, Address, & Phone #</i>			
<i>Spouse's Name</i>	<i>Spouse's Employer Name, Address, & Phone #</i>			
<i>In the event of an emergency, who may we contact (other than spouse)? Name, Address, & Phone #</i>				
<i>What is your reason for this visit? (Please list your health concerns)</i> _____				
<i>What are your health goals?</i>				
<i>Have you had similar conditions before? If so, for how long?</i> _____				
<i>Doctors you have seen for this condition:</i> _____				
<i>Have you been to a chiropractor before?</i> _____				
<i>Who may we thank for referring you?</i> _____				

*If you cannot keep your appointment for any reason, **please contact the office.***

Failure to contact the office may result in a broken appointment fee.

A broken appointment affects three people: you, the doctor and another patient who needs the time. Thank you!

Fees are payable at the time services are rendered, unless other arrangements are made in advance.

X-Rays remain the property of this office.

Signature _____ **Date** _____