The Roselle Center for Healing | 8500 Executive Park Avenue, Suite 300, Fairfax, VA 22031
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WELCOME TO ROSELLE CENTER FOR HEALING

Today's Date _____ **Please Print:**

PERSONAL INFORMATION

NAME:_____ SOCIAL SECURITY:_____ PHONE:_____

MOBILE NUMBER:_____ EMAIL ADDRESS:_____

ADDRESS:_____CITY:_____ STATE: _____ ZIP CODE:_____

AGE: _____ DATE OF BIRTH:_____ SEX: M / F MARITAL STATUS:_____ CHILDREN?_____

OCCUPATION:_____ EMPLOYER:_____

ADDRESS:_____ WORK NUMBER:_____

NAME OF SPOUSE:_____ OCCUPATION: _____ WORK NUMBER:_____

EMERGENCY CONTACT:_____ PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US?_____(Please write in name of person or event)

HEALTH HISTORY

PURPOSE OF THIS
APPOINTMENT:_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES_____ NO _____ COMES AND GOES _____

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? _____

WHAT DO YOU BELIEVE IS WRONG WITH YOU?_____

WHAT POSITIONS OR ACTIVITIES AFFECT YOUR CONDITION?_____

OTHER DOCTORS SEEN FOR THIS CONDITION:_____

DO YOU TAKE ANY VITAMINS? YES___ NO ___ DO YOU THINK YOU MIGHT NEED VITAMINS OR MINERALS? YES_____ NO _____

ARE YOU WEARING HEEL LIFTS? _____, SOLE LIFTS_____ INNER SOLES _____ OR ARCH SUPPORTS_____

DO YOU HAVE TINGLING OR NUMBNESS IN : SHOULDERS___ARMS___ELBOWS___HANDS___HIPS____LEGS___KNEES___ FEET____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? YES____ NO ____ DESCRIBE_____

SERIOUS ILLNESS?_____

WHAT OPERATIONS HAVE YOU HAD?_____

DATE OF LAST PHYSICAL:_____ FEMALE: ARE YOU PREGNANT YES_____ NO _____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? (Including birth control pills)_____

_____ DATE OF LAST SPINAL X-RAY:_____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC/ ACUPUNCTURE CARE? YES _____ NO _____ DOCTOR'S NAME:_____

ADDITIONAL INFORMATION YOU WOULD LIKE TO TELL US:_____

_____

PLEASE PRINT:

Shoe Size:_____ **Width:**_____

HAVE YOU EVER SUFFERED FROM: **(#1 Constant) (#2 Often) (#3 Seldom)**

☐ **Allergies**	☐ **Excessive menstrual flow**	☐ **Deafness**	☐ **Sinus Infections**
☐ **Dizziness**	☐ **Hot Flashes**	☐ **Ear Noises**	☐ **High Blood Pressure**
☐ **Fatigue**	☐ **Irregular Cycle**	☐ **Thyroid**	☐ **Low Blood Pressure**
☐ **Headaches**	☐ **Drug Addiction**	☐ **Eye Pain**	☐ **Pain Over Heart**
☐ **Loss of sleep**	☐ **Depression**	☐ **Failing Vision**	☐ **Poor Circulation**
☐ **Ulcers**	☐ **Numbness**	☐ **Venereal Disease**	☐ **Rapid Heart Beat**
☐ **Nervousness**	☐ **Polio**	☐ **Bed Wetting**	☐ **Slow Heart Beat**
☐ **Arthritis**	☐ **Sciatica**	☐ **Lumps in Breast**	☐ **Anemia**
☐ **Bursitis**	☐ **Spinal Curvature**	☐ **Alcoholism**	☐ **Stroke**
☐ **Foot Trouble**	☐ **Swollen Joints**	☐ **Nausea**	☐ **Chest Pain**
☐ **Low Back Pain**	☐ **Diarrhea**	☐ **Tuberculosis**	☐ **Difficult Breathing**
☐ **Frequent Urination**	☐ **Difficult Digestion**	☐ **Bruise Easily**	☐ **Pleurisy**
☐ **Kidney Infections**	☐ **Hemorrhoids**	☐ **Hay Fever**	☐ **Spitting**
☐ **Kidney Stones**	☐ **Immune Deficiency Syndrome**	☐ **Nosebleeds**	☐ **Swelling of Ankles**
☐ **Prostate Trouble**		☐ **Asthma**	☐ **Cancer**
☐ **Cramps or Backache**		☐ **Colds**	☐ **Diabetes**

CHECK OFF

HABITS	HEAVY	MODERATE	LIGHT	NONE		HABITS	HEAVY	MODERATE	LIGHT	NONE
Dairy						**Appetite**				
Alcohol						**Sodas**				
Drugs						**Tea**				
Exercise						**Sweets**				
Coffee						**Water**				
Sleep						**Tobacco**				

BILLING INFORMATION

IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF YOUR EMPLOYMENT? YES ____ NO ____

DATE SYMPTOM APPEARED OR ACCIDENT HAPPENED:_____ **SAME OR SIMILAR CONDITION? YES ____ NO ____**

HAVE YOU LOST ANY DAYS FROM WORK? YES ___ NO ____

NAME OF HEALTH INSURANCE:_____ **PHONE#:**_____

PAYMENT IS EXPECTED IN FULL AT TIME OF VISIT:

NAME OF PERSON RESPONSIBLE FOR PAYMENT:_____

I understand and agree that health and accident insurance polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare some reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand agree ***that all services rendered me are charged directly to me and that I am personally responsible for payment.*** I also understand that balances that are 90 days or older will accumulate 9.5% interest. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further understand that if I fail to pay this bill and it is turned over to an attorney or (collection agency) for collections that I will be responsible for all legal fees, court fees and collection agency fees.

PATIENTS SIGNATURE:_____ **DATE:**_____

PARENT OR GUARDIAN AUTHORIZING CARE:_____ DATE:_____

Information taken by:_____ **Date:**_____