Robert J. Zapf, M.S., D.C.

New Patient Intake Form

3921 Blenheim Blvd., Suite 71A, Fairfax, VA 22030-2429 | Phone: (703) 455-9555 | www.virginiabackdoctor.com

1. PATIENT INFORMATION

Full Name:	**DOB:** ____/____/_____	**Gender:** □ M □ F
Preferred Name:	**Cell / Mobile:**	**Home Phone:**
Email Address:		
Home Address:		**Zip:**
Emergency Contact:	**Relationship:**	**Phone:**
How did you hear about our office? □ Google / Website □ Physician Referral □ Friend / Family □ Other:		

2. PRIMARY CONCERN & CONDITION FOCUS

Please check all conditions or symptoms you are seeking care for today:		
□ Low Back Pain	□ Sciatica / Leg Pain	□ Herniated / Bulging Disc
□ Neck Pain	□ Sacroiliac (SI) Joint Pain	□ Hip Pain
□ Headaches / Migraines	□ Shoulder Pain	□ Whiplash Injury
□ Knee Pain & Arthritis		□ Numbness / Tingling (Arms/Legs)
Briefly describe your chief complaint:		
Date condition began: ____/____/_____	**How did it start?** □ Gradual □ Sudden □ Auto Accident □ Lifting/Bending □ Work Injury	

3. PAIN SEVERITY & CHARACTERISTICS

Pain Severity Scale (0 = No Pain, 10 = Severe / Emergency Level):

Current Pain: _____ / 10 | Best Pain (Past Week): _____ / 10 | Worst Pain (Past Week): _____ / 10

Pain Frequency: □ Constant (76–100%) □ Frequent (51–75%) □ Occasional (26–50%) □ Intermittent (0–25%)

Pain Quality (check all that apply):

□ Sharp / Stabbing	□ Dull / Aching	□ Burning / Hot	□ Throbbing
□ Stiff / Tight	□ Shooting / Electric	□ Numbness / Tingling	□ Deep Joint Ache

Does pain travel or radiate anywhere? □ No □ Yes

If Yes, describe location:

_____

4. AGGRAVATING & RELIEVING FACTORS

What makes your symptoms WORSE?		**What makes your symptoms BETTER?**
□ Sitting	□ Standing	□ Rest / Lying Down
□ Walking	□ Bending Forward	□ Ice Packs □ Heating Pad
□ Bending Backward	□ Lifting / Carrying	□ Walking / Gentle Movement
□ Driving	□ Lying Down	□ Stretching / Changing Positions
□ Coughing / Sneezing	□ Morning Stiffness	□ Over-the-counter Pain Meds
		□ Prescription Meds / Other: _____

5. PRIOR CARE & DIAGNOSTIC IMAGING

Have you had prior episodes of this issue? □ No □ Yes **If Yes, when?**

_____

Have you had X-rays, MRI, or CT Scans for this condition? □ No □ Yes

If Yes, specify scan type, body region, facility, and approximate date: _____

Previous treatments tried for this condition (check all that apply):

□ Chiropractic	□ Physical Therapy	□ Injections / Epidural	□ Surgery

6. HEALTH HISTORY & MEDICATIONS

Current Medications & Key Supplements:		
Past Surgeries & Major Injuries:		
Medical Conditions Diagnosed (check all that apply):		
□ Osteoporosis / Osteopenia	□ Arthritis / Degenerative Disc	□ High Blood Pressure
□ Diabetes	□ Scoliosis	□ Pacemaker / Heart Condition
□ Cancer History | Type & Year:		

7. SAFETY & CLINICAL TRIAGE SCREEN

Unexplained fever, chills, or night sweats	□ Yes □ No
Unexplained or unintentional weight loss	□ Yes □ No
Recent loss of bowel or bladder control / numbness in groin or saddle area	□ Yes □ No
Progressive weakness in legs/arms or "foot drop" (tripping / catching toes)	□ Yes □ No
Dizziness, double vision, or difficulty swallowing associated with neck movement	□ Yes □ No

8. FUNCTIONAL & DAILY IMPACT

How is your condition impacting your everyday life? (Check all that apply):

□ Sleep disturbance / Cannot find a comfortable sleeping position
□ Difficulty sitting at desk or performing work responsibilities
□ Difficulty walking, standing, or climbing stairs
□ Inability to exercise, stretch, or participate in recreational activities
□ Difficulty with household chores, personal care, or bending over

9. CONSENT TO EXAMINATION & OFFICE ACKNOWLEDGEMENT

Informed Consent & Treatment: I hereby request and consent to the performance of chiropractic examination, diagnostic procedures (including orthopedic and neurological testing), and clinical management as deemed appropriate by Dr. Robert J. Zapf, D.C.

Accuracy of Information: I certify that the information provided on this intake form is true, accurate, and complete to the best of my knowledge.

Financial Responsibility: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that I am financially responsible for all charges incurred for services rendered.

Patient / Guardian Signature:	**Date:** ____/____/_____
Printed Name:	