GLIDE
CHIROPRACTIC CARE

Dr. Lily Moezi-Vaziri, D.C.
1039 Sterling RD ♦ Herndon, VA 20170
Phone: (571) 306-7641 ♦ Fax: (571) 313-3598

Confidential Patient History

Patient _____ Date: _____ DOB:_____
Address:_____
Email:_____

Height: _____ Weight: _____ Referred by: _____
Major complaint and symptoms:

_____
How do you believe your problem (pain) began?

_____
When did you first notice this problem/pain?_____
Which positions or activities aggravate your condition?

_____
Which positions or activities relieve your condition?

_____
Have you ever been treated by any other physicians for this ailment? Yes / No
If yes, where?

_____
Diagnosis of previous physician

_____
Length of time under care _____ Results _____

General Health Questionnaire

Do you have vertigo (dizziness)?..... Yes / No
Do you pass out easily (faint or loss of consciousness)?..... Yes / No
Do you have double vision or have you lost sight in one eye? ..... Yes / No
Do you have any slurred speech or difficulty with speech? ..... Yes / No
Do you have indigestion or difficulty swallowing? ..... Yes / No
Do you have any difficulty walking, with coordination or falling to one side? ..... Yes / No
Do you have nausea or vomiting? ..... Yes / No
Do you have numbness on one side of your face or body? ..... Yes / No
Do you have any visual disturbances or rapid eye movement? ..... Yes / No
Do you have or have you ever had difficulty in arranging words properly? ..... Yes / No
Do you have a headache or head pain that is unlike any you have had before? .. Yes / No
Do you have headaches for hours or days? ..... Yes / No
Do you have a history of stroke in your family? ..... Yes / No
Do you have chest pain? ..... Yes / No
Do you have a sore that does not heal? ..... Yes / No
Do you have any unusual bleeding or discharge? ..... Yes / No
Do you have a nagging cough or hoarseness? ..... Yes / No
Do you have night sweats? ..... Yes / No
Do you have pain in the neck, jaw or face? ..... Yes / No
Do you have a drooping eyelid or change in your pupils? ..... Yes / No
Do you have any ringing in your ears? ..... Yes / No
Have you ever had cancer? ..... Yes / No
Does your pain ever wake you from a sound sleep? ..... Yes / No
Are you losing any weight now without trying? ..... Yes / No
Have you had any loss of bladder or bowel control? ..... Yes / No
Have you lost consciousness or had double vision recently? ..... Yes / No
Do you take birth control pills? ..... Yes / No

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Are you taking any prescription medications? ..... Yes / No
If yes, please list
_____

Are you taking herbs, supplements, botanicals, or vitamins?..... Yes / No
If yes, please list
_____

Are you taking any medication or overthecounter drugs? (aspirin, etc.)..... Yes / No
If yes, Please list
_____

Are you seeing any other doctor now for any reason? ..... Yes / No
If yes, please explain
_____

(Women only) Do you have any reason to believe that you may be pregnant? ..... Yes / No
What operations have you had? Please include cosmetic surgery, etc.
_____ Year _____
_____ Year _____

SOCIAL HISTORY

Smoker?.....Yes / No
If yes, how many packs a day? _____ Years? _____
Alcohol?.....Yes / No
If yes, how much? _____ Years? _____

FAMILY HISTORY

Did your mother or father have any of the following: Put an M for mother, F for father, and B for both.

___ High Blood Pressure
___ Ulcer or Stomach Problems
___ Heart Attack (At what age) F:_____ M:_____
___ Stroke (At what age) F:_____ M:_____
___ Emphysema
___ Seizure/Convulsions
___ Arthritis
___ HIV Positive
___ Mental Illness
___ Asthma
___ Thyroid Disease
___ Diabetes
___ Circulation Problems
___ Kidney Disease
___ Cancer

Are you currently being treated or have you ever been treated for ANY condition not listed above? Please list the conditions
and treatment: _____

Patient signature: _____ Date: _____