Patient Information

Name: ________________________________ Sex: ☐ Male ☐ Female

Address: ________________________________ Home Phone:________________________

Email:________________________________ Cell Phone: ________________________

Date of Birth: ______ / ______ / __________ Work Phone: ________________________

Employer: ________________________________ Occupation:________________________

Marital Status: ☐ Single ☐ Married ☐ Other

Spouse/Emergency Contact Name:__________________ Contact Number:________________

Primary Care Physician: ____

Practice: Contact Number: ____

Orthopedist: ____

Practice: Contact Number: ____

How did you hear about us?____

Insurance:

Group Policy____ Personal Policy____ Work Comp____ Auto Liability____

Insurance Company:__________________ Member ID/Claim #______________________

Company Address:__________________ Adjuster Name and #:________________________

Name of Insured:________________________ Relationship to Patient:__________________

Person Responsible for Account:____

Attorney (**if Auto or WC**):________________________ Attorney Ph #:________________________

Please Note:
Chiropractic Benefits vary depending on your health plan. While we make every effort to provide you with accurate benefit information regarding costs, the patient is personally responsible for services rendered.

If you wish to cancel your appointment we ask that you please give us a 24-hour notice. Continued failure to show-up for scheduled appointments may result in a $25 missed appointment fee.

I understand and agree to the above statement(s):

Signature:______________________ Date:____________________

Health History

Primary reason for today's visit? ____

When did your symptoms appear? ____ Where is your pain located?

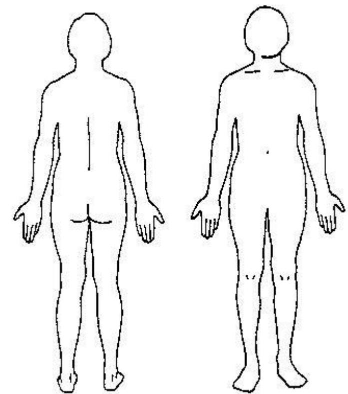
Have you had this pain before? Yes No

Have you received treatment for this condition? Yes No

If "yes", who is treating you for this condition? ___________________________________

What type of treatment did you receive? Chiropractic PT Other: __________________

Have you received chiropractic care in the past? Yes No If so, when? _____________



Please list any **medical conditions** you are being treated for and by whom:

____

____

What makes your pain **worse**?

☐ standing ☐ sitting ☐ twisting ☐ bending ☐ lying down ☐ walking other________

What makes your pain **better**?

☐ standing ☐ sitting ☐ twisting ☐ bending ☐ lying down ☐ walking other________

Type of pain:

☐ sharp ☐ dull ☐ throbbing ☐ shooting ☐ burning ☐ aching ☐ tingling ☐ stiffness ☐ numb

Rate the **severity** of your pain on a scale of 0 (no pain) to 10 (severe pain):

0 1 2 3 4 5 6 7 8 9 10

Does your pain **radiate** from one area to another? Yes No

If yes, explain: ____

Is your pain constant? Yes No Does the pain come and go? Yes No

Is there a time of day that your pain is worse (e.g. morning or night)? _________________________________

Have you had any major surgeries or hospitalizations? ____

Do you have any allergies? ____

Are you currently taking any medications, OTC drugs, or supplements? Please list (or attach):

____

____

____

Are you pregnant? No Yes Due Date: _____________

Do you have children? No Yes Do you have any history of miscarriages? No Yes

Please circle all that apply

Exercise	Work Activity	Habits
None	Sitting	Smoking—packs/day: ____________
Moderate	Standing	Alcohol—drinks/week: ____________
Daily	Light Labor	Coffee/Caffeine—cups/day ________
Heavy	Hard Labor	Stress Levels: __________________

Health Physical

Date of last (Month/Year):

Physical Exam: ____________ Blood test: ___________________ Urine test: ___________________

X-Ray: __________________ Chest X-Ray: ________________ MRI, CT, Bone Scan: __________

Injuries/Surgeries:	Description:	Date:
Falls	____	___________
Head Injuries	____	___________
Broken Bones	____	___________
Dislocations	____	___________
Surgeries	____	___________

Review of Systems - Have you ever had any of the following?

Cardiovascular
☐ **No to all**

☐ Poor Circulation
☐ High Blood Pressure
☐ Aortic Aneurysm
☐ Heart Disease
☐ Vascular Disease
☐ Heart Attack
☐ Chest Pain
☐ High Cholesterol
☐ Pace Maker

Respiratory
☐ **No to all**

☐ Asthma
☐ Tuberculosis
☐ Shortness of Breath
☐ Emphysema
☐ Bronchitis
☐ Pneumonia
☐ Cold/Flu
☐ Cough/Wheezing
☐ Sputum
☐ Coughing Blood

Musculoskeletal
☐ **No to all**

☐ Gout
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Joint Stiffness
☐ Muscle Weakness
☐ Osteoporosis
☐ Fractures
☐ Joint Replacement
☐ Disc Herniation
☐ Hernia

Allergic/Immunologic
☐ **No to all**

☐ Hives
☐ Immune Disorder
☐ HIV/AIDS
☐ Allergy Shots
☐ Cortisone Use

Neurological
☐ **No to all**

☐ Stroke
☐ Seizures
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Brain Aneurysm
☐ Numbness
☐ Pinched Nerves
☐ Carpal Tunnel
☐ Balance Problems

Head
☐ **No to all**

☐ Headaches
☐ Severe Headaches
☐ Migraines
☐ Head Injury

Skin
☐ **No to all**

☐ Skin Lesions
☐ Skin Ulcers
☐ Skin Disease/Cancer
☐ Eczema
☐ Psoriasis

Gastrointestinal
☐ **No to all**

☐ Gallbladder Problems
☐ Bowel Problems
☐ Constipation
☐ Liver Problems/Disease
☐ Ulcers
☐ Diarrhea
☐ Nausea/Vomiting
☐ Bloody Stools

Genitounrinary
☐ **No to all**

☐ Kidney Disease
☐ Lower Side Pain
☐ Burning Urination
☐ Frequent Urination
☐ Blood in Urine
☐ Kidney Stones
☐ Menopausal
☐ Menstrual Problems

Hematologic/Lymphatic
☐ **No to all**

☐ Hepatitis
☐ Blood Clots
☐ Cancer
☐ Easy Bruising
☐ Easy Bleeding
☐ Fevers/Chills/Sweats

Endocrine
☐ **No to all**

☐ Thyroid Disease
☐ Diabetes
☐ Hair Loss

Psychiatric
☐ **No to all**

☐ Depression
☐ Anxiety Disorder
☐ Eating Disorder
☐ Unusual Stress

Ears/Nose/Throat
☐ **No to all**

☐ Hearing Loss
☐ Sinus Infection
☐ Nosebleed
☐ Sore Throat
☐ Difficulty Swallowing
☐ Bleeding Gums

Eyes
☐ **No to all**

☐ Glaucoma
☐ Double Vision
☐ Blurred Vision

General
☐ **No to all**

☐ Weight Loss
☐ Weight Gain
☐ Energy Level Problem
☐ Anemia
☐ Difficulty Sleeping

I acknowledge that all information and answers given on this form are accurate to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my health or health condition.

Patient signature: ____ Date: _________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes:

Treatment, payment, and health care options.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes physical examination, scheduling other exams or appointments with other providers, physician-to-physician discussion for coordination of care, and physician-to-staff for coordination of care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our own practice on a daily basis. The functions include, the entire staff having access to your file to obtain authorization of medical procedures, filing paperwork, recording phone messages or vitals from your visit, confirming your appointment with our office, scheduling your appointment with our office, obtaining the medical complaint for your visit and dictating notes to an outside source of your visit.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any given time. You will then be required to review and resign acknowledging the changes and consenting to the changes.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures of family members, other relatives, close personal friends, or

- any other person identified by you.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations
- The right to inspect and copy your protected health information.
- The right to amend your protected information.
- The right to receive accounting of disclosure of protected health information.
- The right to receive a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 1, 2008, and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

You have the recourse if you feel that your privacy protections have been violated.

You have the right to file a formal complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of this office.

Please contact us for more information, by asking to speak to our Privacy Officer at (703) 753-0974. For written inquires, note "Attention Privacy Officer" at 14535 John Marshall Highway Suite 203, Gainesville, VA 20155.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in my treatment indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but, if you do agree, then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except if you have taken action relying on this consent.

Signature on File:

- I authorize use of this form on all insurance submissions pertaining to my care.
- I authorize release of information to my insurance company.
- I authorize my doctor to act as my agent in helping me to obtaining payment from my insurance company.
- I authorize direct payment to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Patient Name: ______________________________________

Signature: ____ Date: _____________

Relationship to Patient: _______________________________

Consent to Treat

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:

b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke.

I have been informed of the nature of my disorder(s) and of the nature and purpose of Chiropractic/Physical Therapy procedures proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternate treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.

I consent to the chiropractic treatments offered or recommended to me by my chiropractic physician including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Dated this __________ day of ______________________________20____

____ ______________ __________________________
Patient Signature (Legal Guardian) Witness of Signature

Name ____ Name:___________________________________
(Please print)

Please complete the following if the patient is a minor or unable to consent:

Patient's Name: ____Patient's Age: ___________

Name of person legally authorized to sign for this patient: ____________________________

Relationship: ________________

Signature of authorized person: ______________________________ Date: ______________

Provider's Signature: _______________________________________ Date: ______________