**The Chiropractic Associates, LLC**
1240 North Pitt St • Alexandria VA 22314
**Phone:** 703-739-0456 • Fax: 703-739-0032

# CONFIDENTAL PATIENT CASE HISTORY

**Dear Patients:** Please complete this questionnaire. Your answers will help us determine if chiropractic care can benefit you. If we do not sincerely believe your condition will respond satisfactorily, we reserve the right to not accept your case. **THANK YOU!**

Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Age: _____ Birth Date: _____ Marital Status: S M D W P # of Children: _____

Occupation: _____ Spouse or Partner's Name: _____

Referred By: _____ Emergency Phone: _____

## HEALTH INFORMATION:

Date of last physical examination: _____

Have you had prior chiropractic care? Yes ☐ No ☐ If yes, when? _____

What is your major complaint? _____ Onset of complaint/condition(s): _____

How long have you had this condition? _____ Have you had this conditions in the past? Y N

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and Goes ☐

Is this condition interfering with: Work ☐ Sleep ☐ Daily Routine ☐ Other: _____

Do other family members have similar problems? Yes ☐ No ☐

Please list: _____

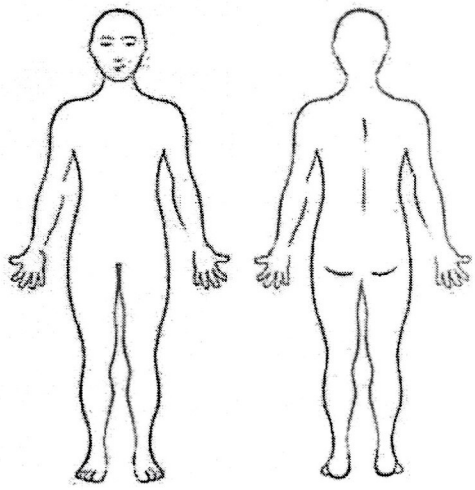
Other doctors who have treated this condition? _____

List any surgical procedures and years: _____

List any drugs you are currently taking: _____

Are you wearing foot/arch supports/heel lifts? Yes ☐ No ☐

Age of your mattress? _____ Comfortable ☐ Uncomfortable ☐



Please outline on the diagram the area of your discomfort.

**FEMALE ONLY:** Is there any chance that you may be pregnant? Yes ☐ NO ☐

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Have you ever been involved in an auto accident? Past year ☐ Past 5 years ☐ Over 5 years ☐ Never ☐

Describe: _____

Have you had any other accident(s) or personal **or** job related injury? Past year ☐ Past 5 years ☐ Over 5 years ☐ Never ☐

Describe: _____

Have you suffered from?

- ☐ Allergies
- ☐ Arm Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Backaches
- ☐ Carpal Tunnel
- ☐ Cold Feet / Cold Hands
- ☐ Concentration Problems
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Dizziness
- ☐ Elbow Pain
- ☐ Fatigue
- ☐ Hand / finger / wrist pain
- ☐ Headaches
- ☐ Heart Trouble
- ☐ Hip / Thigh Pain
- ☐ Knee Pain
- ☐ Loss of Balance
- ☐ Low Back Pain
- ☐ Menstrual pain / irregular
- ☐ Mid Back Pain
- ☐ Mood Swings / Depression
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness in fingers / hands
- ☐ Numbness in toes / feet
- ☐ Pain between Shoulders
- ☐ Pain Down Back or Leg
- ☐ Pins & Needles
- ☐ Ringing / Buzzing ears
- ☐ Shoulder Pain
- ☐ Sinus Trouble
- ☐ Sleep Disorders
- ☐ Tension
- ☐ Other: _____

## AUTO ACCIDENT/MEDICARE:

Is your condition due to an auto accident or job related injury? Yes ☐ No ☐

Are you covered by Medicare? Yes ☐ No ☐ If **YES**, please provide Medicare # _____

## Non-participating Provider with Insurance

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic Associates will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____

**FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health).**

| NAME | RELATION | PAST AND PRESENT HEALTH PROBLEMS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Emergency Contact: _____

Phone Number: _____

# THE CHIROPRACTIC ASSOCIATES

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working with the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

As a chiropractic patient, it is important that you are always aware of some terminology that will be used in practice. This will give you a better understanding of chiropractic care.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if, during a chiropractic spinal examination, we encounter non-chiropractic or usual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference in the expression of the body's innate wisdom to heal itself. Our only method is specific adjusting to correct vertebral subluxation.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor / child:

I, _____, Being the patient or legal guardian, have read and fully understand the above terms of acceptance and hereby grant permission of my child to receive chiropractic care.

PLEASE SIGN BACK

# MISSED APPOINTMENTS / CANCELLATIONS POLICY

## WE PROVIDE SERVICES BY APPOINTMENT ONLY

IF YOU CANNOT MAKE YOUR APPOINTMENT,
PLEASE GIVE US 24 HOURS NOTICE TO AVOID BEING
CHARGED $50.00 FOR THE TIME YOU HAVE RESERVED

IF YOU NEED A DETAILED REOPT OR TREATMENT
OR FOR AN ACCIDENT CASE, AND ADDITONAL FEE OF $80.00
WILL BE CHARGED.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____