1240 NORTH PITT ST #100
ALEXANDRIA , VA 22314
703-739-0456
www.chiroassoc.net

CONFIDENTIAL HEALTH HISTORY

PATIENTS INFORAMTION:

Name: _____ Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (H)_____(C) _____ (W) _____
Email Address: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth:_____

Occupation: _____ Emergency phone: _____

Hours of Work per week: _____

Spouse Name: _____ # of Children: _____ Marital Status: **S M D W P**

Referred By: _____

HEALTH INFORMATION:

Please list your main health concerns: _____

Goals: _____

Any serious illness/hospitalization/injures: _____

Parent Medical History:_____

What is your Blood Type: _____

Do you sleep well?(Yes or No)_____ How many hours?_____

Briefly describe sleep Patterns: _____

_____

Check any of the following that you have or had.

- ☐ Allergies or Asthma
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer (any)
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Eczema - Hives
- ☐ Epilepsy or Seizures
- ☐ Hemorrhoids
- ☐ Migraines
- ☐ High blood Pressure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Thyroid
- ☐ Hernia

Other: _____

Do you take any supplements or medications? If yes, please list:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Any healers, helpers or therapies with which you are involved? If yes, please list: _____

_____

What role does sports and exercise play in your life? _____

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snack	Liquids

What's your food intake like these days?

Breakfast	Lunch	Dinner	Snack	Liquids

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

Will family / friends be supportive of your desire to make food / or Lifestyle changes? _____

_____

_____

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: _____