

BACK IN ACTION SPINECARE & REHAB

8306-C Old Courthouse Road, Vienna VA 22182

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

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

Home Phone: _____ Work Phone: _____ Email: _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name: _____
 Yellow Pages Mail Clinic Location Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance
 Automobile Insurance Worker's Compensation

Name of Insurance Co.: _____ Insured's Employer: _____

Insured's Social Security #: _____ Employer's Phone #: _____

Are you covered by more than one insurance company? Yes No

Name of other insurance: _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition: _____ Date of Last Physical Exam: _____

SURGICAL HISTORY:

1. _____

Date: _____

2. _____

Date: _____

3. _____

Date: _____

Have you ever had a metal implant? Yes No

Ever been gunshot? Yes No

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ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____
 Job Auto Other 2. _____ Date: _____
 Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your symptoms (1-10 with 1 being least serious)

Major Complaints	Symptom Rate
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

DATE OCCURRED: _____

SYMPTOMS ARE WORSE IN Morning Afternoon Night

SYMPTOMS/COMPLAINTS Come & Go Are Constant

SYMPTOMS DEVELOPED FROM: Job Related Injury Auto Accident Accident Illness
 Unknown Cause Gradual Onset Other

SYMPTOMS HAVE PERSISTED FOR # _____ Hour(s) _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

HAVE YOU EVER HAD THIS BEFORE: NO YES When? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES What Kind? _____

ARE YOU TAKING ANY MEDICATIONS NO YES What Kind? _____

ARE YOU PREGNANT NO YES N/A Date of Last Menstrual Period _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

Bending Reaching Straining at Stool Coughing Sitting
 Lifting Sneezing Walking Standing Lying Down Turning Head

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

Bending Sitting Lifting Standing Lying Down Turning Head
 Reaching Walking

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

Blurred vision Buzzing in ears Cold feet Cold hands Cold sweats Concentration loss
/confusion Constipation Depression /Weeping spells Diarrhea Dizziness Face flushed Fainting
 Fatigue Fever Head seems too heavy Headaches Insomnia Light bothers eyes Loss of balance
 Loss of smell Loss of taste Low resistance to colds Muscle jerking Numbness in fingers
 Numbness in toes Pins and needles in arms Pins and needles in legs Ringing in ears Shortness of
breath Stiff neck Stomach upset

Patient's Signature: _____ Date: _____

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Office Use Only

Patient Name: _____ Date: _____

Bp: L: ____/____ R: ____/____
 Pulse: L: ____ R: ____
 SpO₂: ____ %
 Height: _____
 Weight: _____
 Handedness: L R

SOCIAL HISTORY

(Please check the boxes that describe your history with the items below)

Current Weight: _____ Have you recently lost/gained weight? _____

Mental Work Heavy Moderate Light

Physical Work Heavy Moderate Light

Exercise Heavy Moderate Light

Smoking Heavy Moderate Light

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____

Caffeine Cups/Day _____ (coffee, tea, cola)

Aspirin #/Day _____ #/Years _____

PAIN DIAGRAM

Please mark the location of your pain/discomfort. Use the symbols below to represent the type(s) of pain:

B: Burning

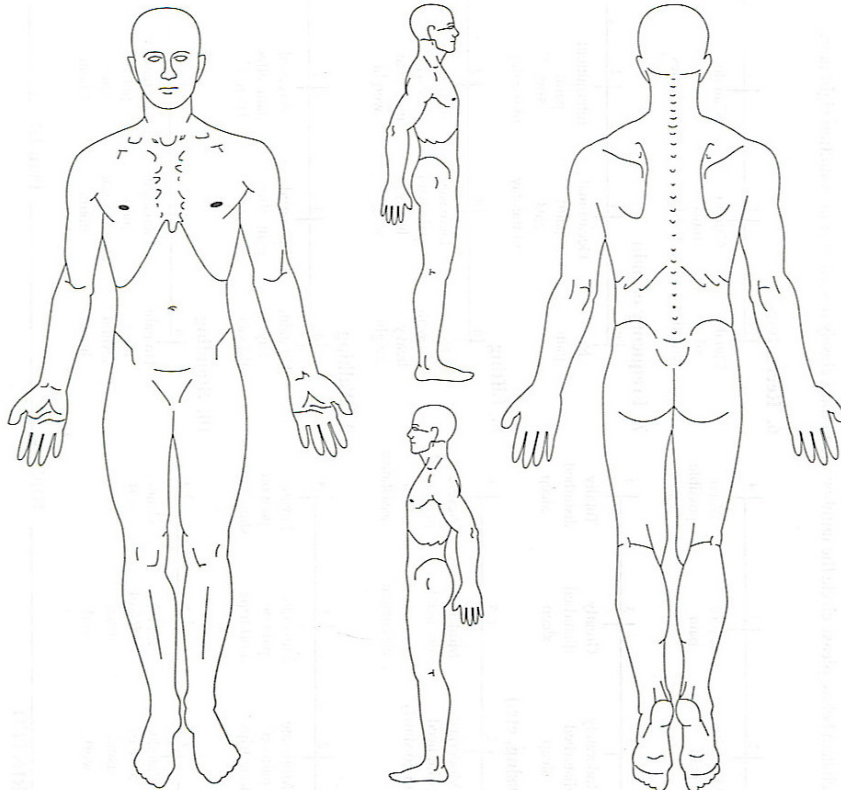
C: Cramping

D: Dull

N: Numb

S: Stabbing/Cutting

T: Tingling (pins & needles)



On the scales below please rate your pain/discomfort (0 being none 10 being severe)

Symptom 1: _____ 0 1 2 3 4 5 6 7 8 9 10
 Symptom 2: _____ 0 1 2 3 4 5 6 7 8 9 10
 Symptom 3: _____ 0 1 2 3 4 5 6 7 8 9 10

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Patient Consent

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

I understand and am informed that, as in all health care, in the practice of Chiropractic, Physical Therapy and Spinal Decompression, there are some risks to treatment, including, but not limited to, muscle strains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I also understand that results are not guaranteed.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

By signing this form, you are granting consent to Back in Action Spinecare & Rehab to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose the protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 703-356-6284. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

I certify that the information given by me in applying for payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim,

I have received and understood this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

Print Patient's Name: _____

Patient's Signature: _____

Relationship to Patient: _____
(If signed by someone other than patient)

Date: _____

Witness: _____