

SUBURBAN HEALTH FAMILY CHIROPRACTIC
8705 Professional Place Manassas, VA 20110
703-393-8228

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone (if available): _____

Age: _____ Birthday: _____ Marital Status: M S W D

Number of Children: _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: _____

Spouse's Name: _____ Occupation: _____

Employer: _____ Office Phone: _____

I was referred by: _____

Patient History

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential.)

NAME: _____ DATE: _____

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date of Onset? _____

Have you lost workdays? Yes No If yes, how many? _____

Have you had this similar condition before? Yes No If yes, when? _____

Was the injury accident related? Auto accident Work accident If yes, when? _____

When was your last auto accident? _____ When was the one before that? _____

Previous Chiropractic Care? Yes No Chiropractor's Name: _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing Chiropractors? _____

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription). _____

Name other doctors you have seen for this condition: _____

What are your health goals? _____

How do you expect to achieve these goals? _____

Please mark if you have had any of these symptoms in the last 12 months:

<input type="checkbox"/> Fractured bones <input type="checkbox"/> Auto accidents ____ 0-1 years ago ____ 1-5 years ago ____ 5 years or more <input type="checkbox"/> Other accidents, falls <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions, epilepsy <input type="checkbox"/> Skin problems <input type="checkbox"/> Cancer <input type="checkbox"/> Frequent colds, flu <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable <input type="checkbox"/> Anemia <input type="checkbox"/> Allergy, sinus <input type="checkbox"/> Under stress <input type="checkbox"/> Eating disorders <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Trouble concentrating <input type="checkbox"/> Learning disability <input type="checkbox"/> Mood changes	<input type="checkbox"/> Neck pain or stiffness R L <input type="checkbox"/> Numbness, tingling, pain in arms, hands, fingers R L <input type="checkbox"/> Jaw pain or click (TMJ) R L <input type="checkbox"/> Difficulty in excessive standing, sitting, riding, bending, lifting, twisting <input type="checkbox"/> Shoulder pain R L <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in ears R L <input type="checkbox"/> Hearing loss <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Upper back pain, stiffness <input type="checkbox"/> Mid back pain, stiffness <input type="checkbox"/> Lower back pain/stiffness <input type="checkbox"/> Pain with cough, sneeze <input type="checkbox"/> Hip pain R L <input type="checkbox"/> Headaches	<input type="checkbox"/> Numbness, tingling, pain in buttocks, legs, feet, toes R L <input type="checkbox"/> Foot trouble R L <input type="checkbox"/> Chest pain, asthma <input type="checkbox"/> Heart problems <input type="checkbox"/> Stroke <input type="checkbox"/> High/low blood pressure <input type="checkbox"/> Varicose veins <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Digestive problems <input type="checkbox"/> Ulcers <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Menstrual problems, PMS <input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Bedwetting <input type="checkbox"/> Ear infections <input type="checkbox"/> AIDS, HIV
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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 towards the same objective.

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

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 adjustment of the spine.

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 vertebrae 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.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

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 to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

All questions regarding the doctor's objectives 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 parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period _____

Signature Date

POLICIES

1. All first visit charges are payable when services rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.
3. Method of payment you plan to use to take care of today's charges?

Cash Check Visa/Mastercard

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand _____ Chiropractic Center will prepare an necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to _____ Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend o terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize _____ Chiropractic Center to obtain a credit report if deemed necessary.

Patient Signature _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____

In case of emergency, notify: _____

Relationship: _____

Address

Phone number
