ACUTE & WELLNESS CHIROPRACTIC CLINIC
9401 CENTREVILLE RD. SUITE #102 MANASSAS, VA 20110
703-257-2555

REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Present Complaints (Please circle the appropriate ones)

Headache	__/10	Feet/Hands Cold	__/10	Unbalanced	__ Yes __ No
Mental dullness	__/10	Depression	__/10	Fainting	__ Yes __ No
Loss of memory	__/10	Rib pain	__/10	Blurred vision	__ Yes __ No
Dizzy	__/10	Nervousness	__/10	Irritability	__ Yes __ No
Neck Pain	__/10	Eye strain/pain	__/10	Double vision	__ Yes __ No
Upper back pain	__/10	Shortness of breath	__/10	Loss of smell	__ Yes __ No
Lower back pain	__/10	Fear	__ Yes __ No	Chest pain	__/10
Midback pain	__/10	Confusion	__ Yes __ No	Ears ringing/buzzing	__Yes __No
Pins and needles in hands right/left	__/10	Pins and needles in arms right/left	__/10	Pins and needles in legs right/left	__ Yes __ No

Medical Implants: _____ **Medical alerts:** _____

Surgical Implants: _____ **Pregnancy:** **yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by filling in the pain scales above.

Patient Name: _____ Date: _____

Doctor's Initials _____

Medications: *(please list all medications and supplements that you currently take)*

Allergies: *(please list all medications that cause allergic reaction)*

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:
Surgery _____ Date _____

Personal Medical History & Review of Systems:
Please Indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders.

□ asthma	□ pulmonary embolism	□ respiratory arrest
□ COPD	□ pneumonia	□ sleep apnea
□ emphysema	□ tuberculosis	□ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina	□ high blood pressure	□ Irregular heartbeat, arrhythmia
□ heart attack	□ heart murmur, valve disorder	□ penpheral vascular disease
□ congestive heart failure	□ mitral valve prolapses	□ deep vein thrombosis
□ other: _____	□ bleeding problems	

Neurologic Disorders

□ stroke or TIA	□ Parkinson's	□ cerebral palsy
□ peripheral neuropathy	□ MS	□ polio
□ other: _____		

Bone & Joint Disorders

□ osteoarthritis	□ gout	□ osteomyelitis
□ rheumatoid arthritis	□ lupus	□ ankylosing spondylitis
□ other _____		

Patient Name. _____ Date _____

Doctor's Initials _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ Irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer, any type – please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung: _____
□ heart attack, myocardial infarction □ congestive heart failure
□ Irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro: _____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI: _____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer: any type – please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ Date: _____

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PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:
Name & Address:

_____

_____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

_____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

Patient Name: _____ Date: _____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as: informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examination or test conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or and instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and or scarring from electrical stimulation and from hot or cold therapies. Including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated at 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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We may use and disclose your PHI (private health information) in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or another lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers' compensation and similar programs.

We may use a sign-in sheet at the front desk, and we may call you in to see the doctor by name.

We may contact you by mail or phone at your residence to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment, and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor, and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you to carry out treatment, payment, or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name of Patient or Legal Guardian: _____ Date: _____