  
Spine Care Associates of Alexandria, Inc.  
6285 Franconia Rd. 703-719-7302  
Alexandria, VA 22310  
[www.SpineCareOfAlexandria.com](http://www.SpineCareOfAlexandria.com)

Date \_\_\_\_\_

**NEW PATIENT CASE HISTORY:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_\_  
Address: \_\_\_\_\_ SS# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Single/Married/Divorced  
Hm. # \_\_\_\_\_ Wk.# \_\_\_\_\_ Cell.# \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ # \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Referred By: Internet/ Phonebook/ Insurance/ Coupon/ Other/ Patient \_\_\_\_\_  
Primary Care Phy. \_\_\_\_\_ ph.# \_\_\_\_\_  
Would you like a letter sent to your Primary Care Physician? Y / N  
Email: \_\_\_\_\_  
Previous Chiropractic Care? Y/N If so how long ago? \_\_\_\_\_

**MAIN COMPLAINT:**

Why are you here today?(Please be specific) \_\_\_\_\_

1. When did it start? \_\_\_\_\_ 2. How did it start? \_\_\_\_\_
3. Work related? Y/N , Auto Accident? Y/N , Other Accident? Y/N
4. Does the pain radiate to any other part of your body , if so where? \_\_\_\_\_
5. Did your pain begin **Gradually**, or **Suddenly**? (Circle one)
6. Is your pain **Mild**, **Moderate**, or **Severe**? (Circle one)
7. Is your pain? Circle all that apply: **Dull, Sharp, Burning, Numbness, Soreness, Stiffness.**
8. Has your problem been getting **Better**, **Worse** or the **Same**?
9. Is your pain **Intermittent**, or **Constant**?
10. What makes your symptom **Better**? \_\_\_\_\_ **Worse**? \_\_\_\_\_
11. Have you tried home remedies? \_\_\_\_\_
12. Have you seen any other doctors for this? \_\_\_\_\_
13. Have you had this before? Y/N If so when? \_\_\_\_\_
14. Any changes in body function? **Explain** \_\_\_\_\_
15. Have you lost any work as a result of your current problem? Y/N How Long? \_\_\_\_\_
16. Do you have any other problem you would like the Dr. To evaluate? \_\_\_\_\_

## PAST MEDICAL HISTORY

1. Have you had any of the follow childhood diseases? **Measles, Rubella, Chicken Pox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, Other:** \_\_\_\_\_
2. Have you been diagnosed with any other conditions? \_\_\_\_\_
3. Are you under a doctors care for any condition? **Y/N** \_\_\_\_\_
4. Have you ever broken any bones? **Y/N** \_\_\_\_\_
5. Have you had any past significant auto accidents? **Y/N** When? \_\_\_\_\_
6. Please list any current medications you are taking. \_\_\_\_\_
7. Have you under gone any surgeries? **Y/N** Explain. \_\_\_\_\_
8. Do you drink, smoke or use any recreational drugs? Explain. \_\_\_\_\_
9. Do you have any allergies? **Y/N** Explain. \_\_\_\_\_
10. History of family diseases? Explain. \_\_\_\_\_

Have you ever been diagnosed with any of the following? Please Circle Yes or No.

- |                                     |  |
|-------------------------------------|--|
| <b>Y/N</b> High Blood Pressure      | <b>Y/N</b> Hardening of the arteries           |
| <b>Y/N</b> Diabetes                 | <b>Y/N</b> Heart or blood vessel diseases      |
| <b>Y/N</b> Bone spurs on neck       | <b>Y/N</b> Whiplash injury                     |
| <b>Y/N</b> Blurred or Double Vision | <b>Y/N</b> Relatives who have suffered strokes |
| <b>Y/N</b> Currently Smoke          | <b>Y/N</b> Smoked in the past                  |

Have you had any of the symptoms in the past **Year**?

- |  |  |
|--|--|
| <b>Y/N</b> Slurred speech or speec Problems      | <b>Y/N</b> Difficulty swallowing                         |
| <b>Y/N</b> Dizziness                             | <b>Y/N</b> Temporary lack of understanding               |
| <b>Y/N</b> Loss of consciousness, or Black out   | <b>Y/N</b> Numbess in face, arms, hands fingers, or legs |
| <b>Y/N</b> Any other abnormal loss of sensation  | <b>Y/N</b> Diminished or partial loss of vision          |
| <b>Y/N</b> Weakness, Clumsiness or strength loss | <b>Y/N</b> Hearing loss in one or both ears              |
- Face, arms, hands, fingers, or legs

Men Only:

Date of last prostate exam: \_\_\_\_\_ Difficulty urinating? **Y/N** Frquent Urination? **Y/N**

Women Only:

Are you currently taking Birth control pills? **Y/N** If yes how long? \_\_\_\_\_

**Y/N** Menstrual Pain **Y/N** Cramps **Y/N** Irregularity **Y/N** Pregnant? How long? \_\_\_\_\_

**PAIN DRAWING:**

Circle the Severity of your pain on the line below:

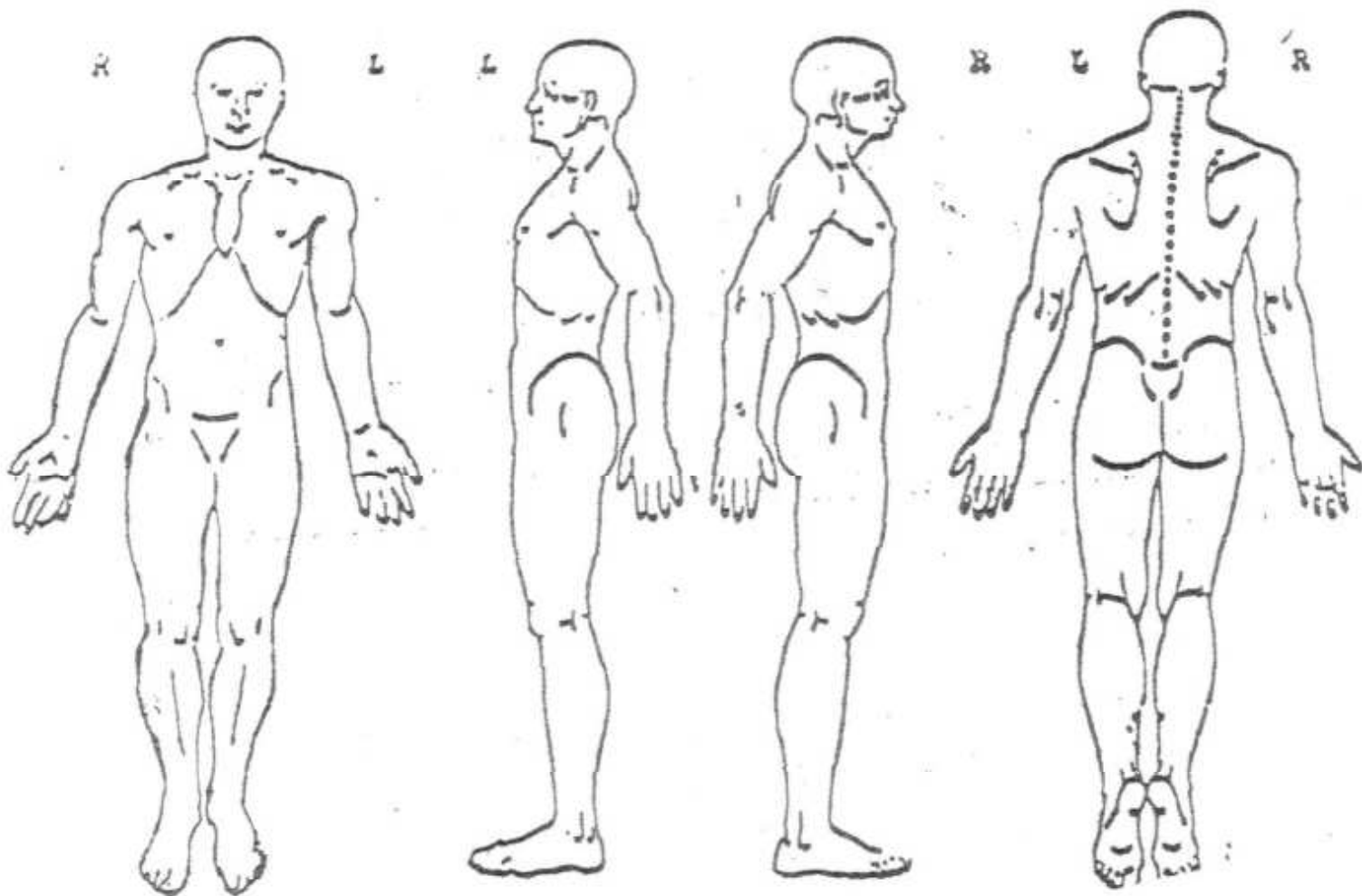
0-1-2-3-4-5-6-7-8-9-10

(No pain)

(Extreme pain)

Mark the location of your pain on the body outlines below using the following Letters:

A=Ache B=Burning N=Numbness P=Pins and Needles S=Stabbing X=Other(Specify)



**Spine Care Associate of Alexandria, Inc.**  
 Insurance Authorization Form    Date \_\_\_\_\_

|                   |                                  |                       |               |
|-------------------|----------------------------------|-----------------------|---------------|
| <b>Last Name:</b> | <b>First Name &amp; Initial:</b> | <b>Date of Birth:</b> | <b>M    F</b> |
|-------------------|----------------------------------|-----------------------|---------------|

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

|             |             |             |
|-------------|-------------|-------------|
| Home Phone: | Cell Phone: | Work Phone: |
|-------------|-------------|-------------|

|                         |        |
|-------------------------|--------|
| Social Security Number: | Email: |
|-------------------------|--------|

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Insurance Subscriber's Name** (Last, First, M.I.): \_\_\_\_\_

|                         |                |                          |
|-------------------------|----------------|--------------------------|
| Social Security Number: | Date of Birth: | Relationship to Patient: |
|-------------------------|----------------|--------------------------|

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Insurance Subscriber's Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

|             |             |             |
|-------------|-------------|-------------|
| Home Phone: | Cell Phone: | Work Phone: |
|-------------|-------------|-------------|

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to Spine Care Associates of Alexandria, Inc., otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. **I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).**

\_\_\_\_\_  
 Signed \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to release information:** I hereby authorize Spine Care Associates of Alexandria, Inc. to release any information acquired in the course of my treatment necessary to process insurance claims.

\_\_\_\_\_  
 Signature (Legal Guardian/Parent, if minor) \_\_\_\_\_ Date \_\_\_\_\_

Waiver:

I, \_\_\_\_\_, agree to be seen by Spine Care Associates on this date. I acknowledge that I did not bring a referral as required by my insurance company and/or I do not have my insurance card. I am electing to be seen today and agree to pay for services rendered since I do not have a valid referral or insurance card.

\_\_\_\_\_  
 Signed \_\_\_\_\_ Date \_\_\_\_\_

**Spine Care Associates of  
Alexandria**

6285 Franconia Rd.  
Alexandria, Virginia 22310

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. 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.

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

\_\_\_\_\_  
Witness to Patients' Signature