Spine Care Associates of Alexandria, Inc.
6285 Franconia Rd. 703-719-7302
Alexandria, VA 22310
www.SpineCareOfAlexandria.com

Date___________

NEW PATIENT DEMOGRAPHICS:

Name:_______________________________________ DOB:_________ Age________
Address:_____________________________________ SS#____________________
City:_______________ State:__________ Zip:____________ Single/Married
Hm. #__________________ Wk.#____________________ Cell.#_______________
Employer:____________________ Occupation:___________________
Emergency Contact: Name and Phone # ______________________________________
Ins.Name____________________ Policy/Subscriber#_____________ Grp#_________

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.

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

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

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

PAIN DRAWING:

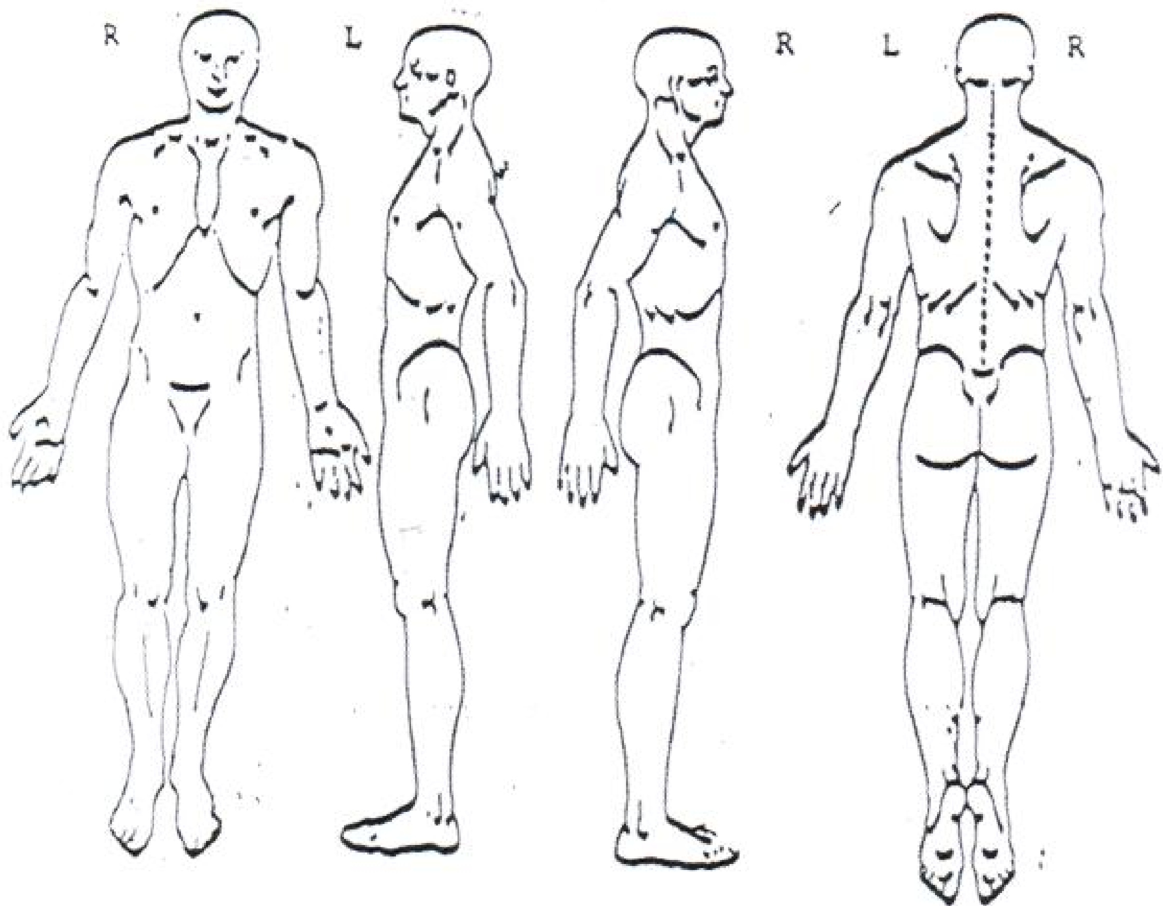
Circle the Severity of your pain on the line below:

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)



I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. If my account is turned over to collection I agreed to pay any additional collection fees. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

NOTICE OF "HIPPA" PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. We strive to provide the best health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. You will be asked to authorize release of PHI to any party that is directly connected to your treatment, payment, or health care operations. If you have any questions, comments, or objections to the privacy policy on this form, please ask to speak with our compliance officer.

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Signature________________________________ Date____________