Dahlgren Chiropractic Clinic
5215 Kings Wood Lane King George Va, 22485

Welcome! **Thank you for trusting us with your chiropractic care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask.**

New Patient Application

(

First Name________________________ Middle Int.______ Last Name________________________

Sex Male ___ Female___ Home Phone_____________ Cell ______________ Work___________

Address____

City________________________________ State___________ Zip______________________________

S.S Number _____-_____-_____Birthday _________ Age ______ Marital Status S M W D

Email Address _______________________________________Job Title________________________

Spouse's Name _______________________________________ Spouse's Birthday_____________

Person responsible for this account ____

Name of person on your health insurance card_______________________Birthday_____________

Name of their employer____________________ City_________________ Phone______________

Children- Names & Ages____

In case of emergency, who should we contact? Name_____________________________________

Phone_________________________________ Relation___________________________________

Family Physician__________________________ May we send updates on your progress? **Y N**

If yes, please provide: Phone________________________ Fax______________________________

What is your primary complaint? ____

Is this worker's compensation? **Y N** Is this related to a recent car accident? **Y N**

Acknowledgments:

To set clear expectations, improve communications and to help you get the best results, please read each statement and initial your agreement.

I acknowledge that my insurance is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non- covered services I receive. Initials _____

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. Initials _____

First Name________________________ Middle Init.______ Last Name______________________________

Dr. Signature: ____ **Date** _____________________

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1. **Reasons for seeking chiropractic care:**

Primary reason:____________________________________ Secondary reason: ____________________________________

Have you ever received Chiropractic Care? Yes No If yes, when? ____________________________

Name of most recent Chiropractor: ____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
____
____
____

3. **Past Health History:**

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Diabetes *(circle)* Type 1 or 2 □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's
□ Cancer If you checked cancer please indicate what type of cancer ____________________________
□ Other______________________________________□ None of the above

B. Previous Injury or Trauma:
____

Have you ever broken any bones? Which?
____

C. Allergies:
____

D. Medications:	**Reason for taking**	**Medications:**	**Reason for taking**
1.	A.	5.	E.
2.	B.	6.	F.
3.	C.	7.	G.
4.	D.	8.	H.

E. Surgeries:

Date	Type of Surgery

Patient Signature____ **Date**________________________

Dr. Signature: ____ **Date** ________________________

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F. **Females/ Pregnancies and outcomes:**

Are you pregnant? Yes No If yes, how many weeks?_______

How may pregnancies have you had?________ Outcome?__________________

Comments:____

4. **Family Health History:** (*Parents, Siblings, Grandparents)*

Do you have a family history of? (Please indicate all that apply)

□ Cancer if yes, what kind _____________________________ □ Strokes/TIA's □ Headaches
□ Cardiac disease □ Neurological diseases□ Adopted/Unknown □ Cardiac disease below age 40
□ Psychiatric disease □ Diabetes (type 1 or 2) □ Other ______________ □ None of the above

Deaths in immediate family: ____

Cause of parents or siblings death Age at death

____

____

Social and Occupational History:

A. **Job Description:** **Work Schedule:**

____

B. **Recreational / Lifestyle:**

____

C. **On AVERAGE how much do you drink? Water______ Glasses/ Daily Caffeine _____ Cups/ Daily Alcohol_______ Glasses / Daily / Weekly/ Monthly**

D. **Smoking Status (Circle that apply) Never A Smoker Former Smoker Current Everyday Smoker Current Sometimes Smoker Heavy Smoker Light Smoker**

Notes/ Comments: ____

____

____

____

Patient Signature ____________________________________ **Date**______________________

Dr. Signature: ____________________________________ **Date** ______________________

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes type 1 or 2 □ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ AIDS □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? __________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with Chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Dr. Judi Morris, D.C, Dahlgren Chiropractic Clinic** for services performed.

Patient signature ____ **Date** _______________________

Dr. Signature: ____ **Date** ________________________

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or **"SPAM"** your personal contact information

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. I acknowledge receipt of a copy of the office 'Notice of Patient Privacy Policy'.

__________________________________ ________________________
Signature of Patient or Representative Date

____
Printed Name

Dr. Signature: ____ **Date** _______________________

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NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 ___________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity: **5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
- When did the symptom begin? ____
  - Did the symptom begin **suddenly** or **gradually**? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - **Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other** (please describe): _____________________________
- What makes the symptom better? (circle all that apply):
  - **Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other** (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - **Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging**

Numbness, Tingling ,Other (please describe): ____________________________________

- Does the symptom radiate to another part of your body (circle one): **yes** **no**
  - If yes, where does the symptom radiate? ____________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - **Morning Afternoon Evening Night Unaffected by time of day**

Symptom 2 ___________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity: **5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
- When did the symptom begin? ____
  - Did the symptom begin **suddenly** or **gradually**? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - **Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other** (please describe): _____________________________
- What makes the symptom better? (circle all that apply):
  - **Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other** (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - **Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging**

Numbness, Tingling, Other (please describe): ___________________________________

- Does the symptom radiate to another part of your body (circle one): **yes** **no**
  - If yes, where does the symptom radiate? ____________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
- **Morning Afternoon Evening Night Unaffected by time of day**

Patient Signature____ **Date**_____________________

Dr. Signature: ____ **Date** _____________________

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Symptom 3 ________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity: **5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
- When did the symptom begin? ________________________________
    - Did the symptom begin **suddenly** or **gradually**? (circle one)
    - How did the symptom begin? ________________________________
- What makes the symptom worse? (circle all that apply):
    - **Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other** (please describe): ____________________
- What makes the symptom better? (circle all that apply):
    - **Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other** (please describe): ________________________________
- Describe the quality of the symptom (circle all that apply):
    - **Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging**

Numbness, Tingling, Other (please describe): ________________________

- Does the symptom radiate to another part of your body (circle one): **yes** **no**
    - If yes, where does the symptom radiate? ________________________
- Is the symptom worse at certain times of the day or night? (circle one)
    - **Morning Afternoon Evening Night Unaffected by time of day**

Symptom 4 ________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity: **5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
- When did the symptom begin? ________________________________
    - Did the symptom begin **suddenly** or **gradually**? (circle one)
    - How did the symptom begin? ________________________________
- What makes the symptom worse? (circle all that apply):
    - **Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other** (please describe): ____________________
- What makes the symptom better? (circle all that apply):
    - **Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other** (please describe): ________________________________
- Describe the quality of the symptom (circle all that apply):
    - **Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging**

Numbness, Tingling, Other (please describe): ________________________

- Does the symptom radiate to another part of your body (circle one): **yes** **no**
    - If yes, where does the symptom radiate? ________________________
- Is the symptom worse at certain times of the day or night? (circle one)
    - **Morning Afternoon Evening Night Unaffected by time of day**

Patient signature ______________________________ **Date** ______________

Dr. Signature: ______________________________ **Date** ______________