BACK IN ACTION HEALTH SOLUTIONS

8306-C Old Courthouse Road, Vienna VA 22182

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Sex: ❑Male ❑Female ❑Other Marital Status: ❑Married ❑Single ❑Divorced ❑Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ **Cell Phone:** _____ **Email**: _____

Emergency Contact: _____ Phone: _____

Your Occupation_____ Your Employer: _____

How did you hear about us? ❑Friend/Family Member – Name: _____

❑Doctor:_____ ❑ Social Media: _____ ❑Other: _____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance ❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co:_____ Insured's Employer:_____

Insured's Name:_____ Insured's Date of Birth:_____

Name of secondary insurance (if you have one): _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by marking appropriate boxes.)

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	Dislocated joints	❑	❑	❑	Neck pain
❑	❑	❑	Anemia	❑	❑	❑	Epilepsy	❑	❑	❑	Nervousness
❑	❑	❑	Arthritis	❑	❑	❑	German measles	❑	❑	❑	Numbness
❑	❑	❑	Asthma	❑	❑	❑	Headaches	❑	❑	❑	Polio
❑	❑	❑	Back pain	❑	❑	❑	Heart trouble	❑	❑	❑	Poor circulation
❑	❑	❑	Bladder trouble	❑	❑	❑	Reproductive disorders	❑	❑	❑	Hepatitis
❑	❑	❑	Bone fracture	❑	❑	❑	High blood pressure	❑	❑	❑	HIV/ARC
❑	❑	❑	Cancer	❑	❑	❑	Rheumatic fever	❑	❑	❑	Rheumatism
❑	❑	❑	Chest pain	❑	❑	❑	Kidney disorder	❑	❑	❑	Scarlet fever
❑	❑	❑	Concussion	❑	❑	❑	Bowel control loss	❑	❑	❑	Serious injury
❑	❑	❑	Convulsions	❑	❑	❑	Venereal disease	❑	❑	❑	Sinus trouble
❑	❑	❑	Diabetes	❑	❑	❑	Multiple sclerosis	❑	❑	❑	Tuberculosis
❑	❑	❑	Indigestion	❑	❑	❑	Muscular dystrophy	❑	❑	❑	Alcoholism

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition: _____ Date of Last Physical Exam: _____

SOCIAL HISTORY(Please check the boxes that describe your history with the items below)

Current Weight: _____ Have you recently lost/gained weight? _____

Mental Work	❑Heavy	❑Moderate	❑Light
Physical Work	❑Heavy	❑Moderate	❑Light
Exercise	❑Heavy	❑Moderate	❑Light
Smoking	❑Heavy	❑Moderate	❑Light

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____

Caffeine Cups/Day _____ (coffee, tea, cola)

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Patient Name:_____ Date: _____

SURGICAL HISTORY:

1. _____ 2. _____
3. _____ 4. _____

Do you have a metal implant? ❑Yes ❑No Where/What kind? _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your symptoms (1-10 with 1 being least serious)	Symptom Rate	Onset Date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

SYMPTOMS ARE WORSE IN: ❑Morning ❑Afternoon ❑Night

SYMPTOMS/COMPLAINTS: ❑Come & Go ❑Are Constant

SYMPTOMS DEVELOPED FROM: ❑Job Related Injury ❑Auto Accident ❑Accident ❑Illness ❑Unknown Cause ❑Gradual Onset ❑Other

SYMPTOMS HAVE PERSISTED FOR: # ____ Hour(s) ____ Day(s) ____ Week(s) ____ Month(s) ____ Year(s)

HAVE YOU EVER HAD THIS BEFORE: ❑No ❑Yes When? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____

NAME & LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):_____

_____

LIST ANY MEDICATIONS OR SUPPLEMENTS: _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES What Kind? _____

ARE YOU ON BLOOD THINNERS? IF SO, WHICH AND WHY: _____

ARE YOU OR COULD YOU BE PREGNANT? ❑NO ❑YES ❑N/A Date of Last Menstrual Period _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑Bending ❑Reaching ❑Straining at Stool ❑Coughing ❑Sitting ❑Lifting

❑Sneezing ❑Walking ❑Turning Head ❑Lying Down ❑Standing

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑Bending ❑Sitting ❑Lifting ❑Standing ❑Lying Down ❑Turning Head ❑Reaching ❑Walking

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

❑Blurred vision ❑Buzzing in ears ❑Cold feet ❑Cold hands ❑Cold sweats ❑Concentration loss /confusion

❑Constipation ❑Depression /Weeping spells ❑Diarrhea ❑Dizziness ❑Face flushed ❑Fainting ❑Fatigue

❑Fever ❑Head seems too heavy ❑Headaches ❑Insomnia ❑Light bothers eyes ❑Loss of balance

❑Loss of smell ❑Loss of taste ❑Low resistance to colds ❑Muscle jerking ❑Numbness in fingers ❑Numbness in toes ❑Pins and needles in arms ❑Pins and needles in legs ❑Ringing in ears

❑Shortness of breath ❑Stiff neck ❑Stomach upset

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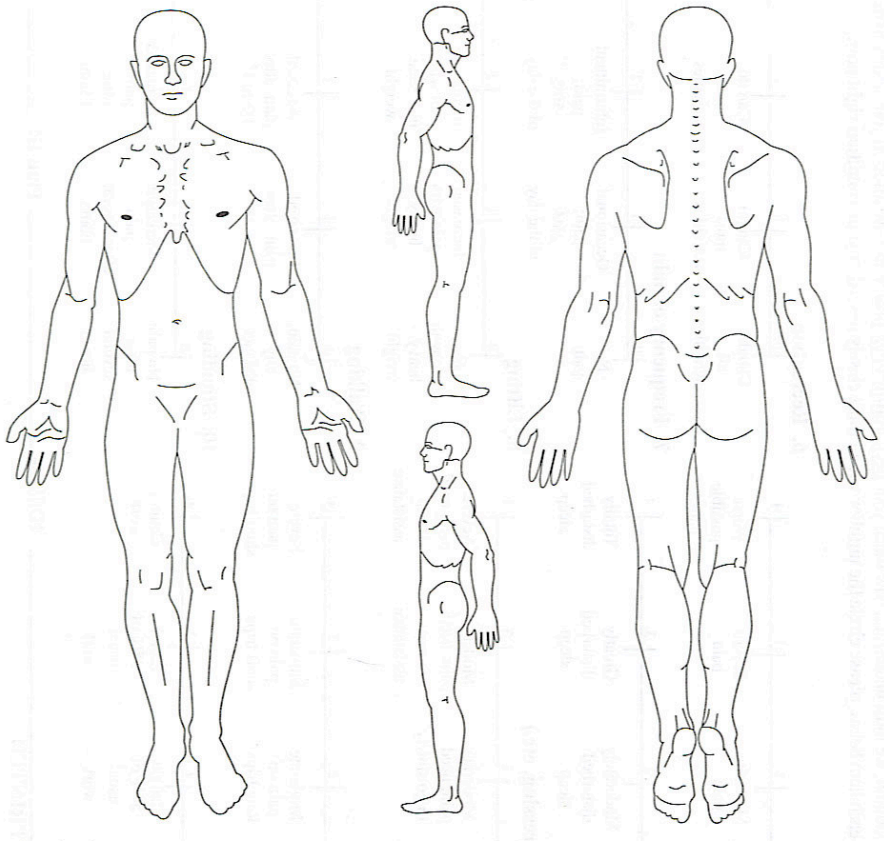
Patient Name: _____ Date: _____

PAIN DIAGRAM

Please mark the location of your pain/discomfort. Use the symbols below to represent the type(s) of pain and it's severity from level of 0-10, 0 = no pain, 10 = severe pain (Example: B6 written on left shoulder)

B: Burning C: Cramping D: Dull
N: Numb S: Stabbing/Cutting T: Tingling (pins & needles)



Office Notes (Staff Only):

Ht: _____ Wt: _____ BP: _____ Pulse: _____ O2 Sat: _____

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Patient Consent

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

I understand and am informed that, as in all health care, in the practice of Chiropractic, Physical Therapy and Spinal Decompression, there are some risks to treatment, including, but not limited to, muscle strains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications 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. I also understand that results are not guaranteed.

I have read the above consent. 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.

RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:
By signing this form, you are granting consent to Back in Action Health Solutions to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose the protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 703-356-6284. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

I certify that the information given by me in applying for payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim,

I have received and understood this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

Print Patient's Name: _____

Patient's Signature: _____

Relationship to Patient: _____
(If signed by parent or guardian)

Date: _____ **Witness:** _____