AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Virginia Family Chiropractic to administer such treatments as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

I hereby certify that I have read and dully understand the above Authorization for Chiropractic treatment, the reason why the above named treatment is considered necessary, the benefits and risks the side effects of the treatment, which were explained to me by Virginia Family Chiropractic.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited, to muscle strains and sprains, fractures, dislocations, disc injuries, strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments which he feels at the time, based upon the facts then known is my best interest.

My doctor has responded to all of my requests for information about proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask about its content. By signing below, I consent to treatment. I also certify that no guarantee of assurance has been made as to the results that may be obtained.

__________________________  ________________________
Print Name                      Date

__________________________
Signature

__________________________
Witness or Nearest Relative
THE FOLLOWING AUTHORIZES VIRGINIA FAMILY CHIROPRACTIC & PM PLLC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATION:

I give permission to Virginia Family Chiropractic PM PLLC to use my name, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages, text messages, and information about treatment alternatives or other health related information.

I give permission to Virginia Family Chiropractic PM PLLC to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following, you are giving Virginia Family Chiropractic PM PLLC permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian  Date

Printed Name of Patient/or Guardian

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures: I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian  Date

Printed Name of Patient/or Guardian
Patient Registration and History Questionnaire

Name:________________________________________ Age:___ Date of Birth:_______ Date:______
Last First MI
Address:______________________________________ Social Security #:_______-_______-________
City, State, Zip:______________________________________________ Marital Status: M S W D
Home Phone: (_____)____________________ Work/Cell Phone: (____) ________
Email: __________________________________________@______.com Employer:__________________________
Occupation:________________________________________ How were you referred to this office?_______________
In case of an emergency, notify ___________________ Relationship:______________ Phone: (____)____________________

Reason for Office Visit:  Date condition started:  Have you had this before?  Injury related?
1.____________________  _______________  [ ] yes [ ] no  [ ] yes [ ] no
2.____________________  _______________  [ ] yes [ ] no  [ ] yes [ ] no
3.____________________  _______________  [ ] yes [ ] no  [ ] yes [ ] no

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:
Pain location:__________________  Pain location:_________________ Pain Location:_____________
RIGHT NOW: _____/10  RIGHT NOW: _____/10  RIGHT NOW: _____/10
At its WORST: _____/10  At its WORST: _____/10  At its WORST: _____/10
At its BEST: _____/10 At its BEST: _____/10 At its BEST: _____/10

What makes your pain BETTER? (Check all that apply):
[ ] Nothing  [ ] Ice  [ ] Heat  [ ] Massage/Rubbing  [ ] Exercise/Activity  [ ] Sitting
[ ] Standing  [ ] Rest  [ ] Stretching  [ ] “Popping” the joints  [ ] Bracing/taping  [ ] Laying

What makes your pain WORSE? (Check all that apply):
[ ] Coughing  [ ] Sneezing  [ ] Bearing Down  [ ] Sexual Intercourse  [ ] Running  [ ] Standing
[ ] Lifting  [ ] Bending  [ ] Pushing  [ ] Pulling  [ ] Driving  [ ] Sitting
[ ] Walking  [ ] Laying Down  [ ] Movement of the head  [ ] Movement of the low back
[ ] Other______________________________________________________________

Pain Quality: How would you describe your pain/discomfort (check all that apply)
[ ] Dull  [ ] Achy  [ ] Stiff  [ ] Intense  [ ] Throbbing  [ ] Sharp  [ ] Sharp with movement
[ ] Stabbing  [ ] Shooting  [ ] Burning  [ ] Constricting  [ ] Annoying  [ ] Tight  [ ] Unbearable
Numbness/Tingling (pins and needles): [ ] Yes, [ ] No: Please describe where and when you feel these symptoms:
____________________________________________________________________________

Are symptoms:
- Constant >75%
- Frequent 51-75%
- Occasional 26-50%
- Intermittent <25% of your waking hours

Have you seen a Chiropractor before? [ ] yes [ ] no Who?
____________________________________________________________________________

When?
Reason for visits?
How did you respond?
____________________________________________________________________________

Medical Doctors:
Name:______________________ Date of last visit:_____ Is this your primary care provider? [ ] yes [ ] no
Name:______________________ Date of last visit:_____ Is this your primary care provider? [ ] yes [ ] no
Name:______________________ Date of last visit:_____ Is this your primary care provider? [ ] yes [ ] no

Surgeries/Hospitalization and dates:
____________________________________________________________________________

Medication: OTC/Prescription/Supplements/Vitamins:
____________________________________________________________________________

Please list all serious illness and serious accidents:
Month and Year: City, State:
____________________________________________________________________________

List any allergies to medications, food or other:
____________________________________________________________________________

Are you pregnant? … Yes … No First day of last menstrual cycle: _____________

Do you smoke? … Yes … No; How much? ______ Do you drink alcohol? … Yes … No; How much? ______

Please list any recent x-rays, lab or other tests:
Month and Year: Facility/Doctor:
____________________________________________________________________________

Do you have a history of any of the following diseases?
Tuberculosis … Yes Lung Disease … Yes Gout … Yes Diabetes … Yes
Kidney Disease … Yes Stomach/Ulcer … Yes Heart Attack … Yes Hepatitis … Yes
Sciatia … Yes Blood Pressure … Yes Transfusion … Yes Polio / MS … Yes
Colon Disease … Yes Stroke … Yes Cancer … Yes Bleeding … Yes
Paralysis … Yes Seizures … Yes Arthritis … Yes Asthma … Yes
Anemia … Yes Thyroid Disease … Yes Drug Dependence … Yes AIDS … Yes

Any other condition(s) not listed above that the doctor should be made aware of:
____________________________________________________________________________
Postural distortions from subluxations in your neck, upper back, middle back and low back will negatively influence and affect the nerves throughout the entire body. Do you NOW or have you EVER experienced:

CERVICAL SPINE (NECK):
[ ] Neck pain  [ ] Headaches  [ ] Pain into shoulders/arms/hands  [ ] Immune system weakness
[ ] TMJ/pain/clicking  [ ] Dizziness/fainting  [ ] Weakness in grip  [ ] Arthritis in the neck
[ ] Allergies/ hay fever  [ ] Allergies  [ ] Visual disturbances  [ ] Hearing disturbances
[ ] Coldness in hands  [ ] Low energy/fatigue  [ ] Recurrent colds/flu  [ ] Thyroid conditions
[ ] Sinusitis  [ ] Depression  [ ] Numbness/tingling in arms/hands  [ ] Anxiety

THORACIC SPINE (UPPER BACK):
[ ] Upper back pain  [ ] Shoulder pain  [ ] Heart attacks/angina  [ ] Pain on deep inspiration/expiration
[ ] Heart palpitations  [ ] Tachycardia  [ ] Shortness of breath  [ ] High blood pressure
[ ] Heart murmurs  [ ] Asthma/wheezing  [ ] High Cholesterol  [ ] Recurrent lung infections/bronchitis

THORACIC SPINE (MID BACK):
[ ] Mid back pain  [ ] Pain into ribs/chest  [ ] Scoliosis  [ ] Kidney disease  [ ] Diabetes
[ ] Ulcers/gastritis  [ ] Indigestion/Heartburn  [ ] Hypoglycemia  [ ] Gall bladder problems  [ ] Nausea
[ ] Acid reflux  [ ] Tired/irritable after eating or when you haven’t eaten for awhile

LUMBAR SPINE (LOW BACK):
[ ] Low back pain  [ ] Pain into hips/legs/feet  [ ] Weakness/injuries in hips/knees/ankles
[ ] Numbness/tingling in legs/feet  [ ] Muscle cramps in legs/feet  [ ] Coldness in legs/feet
[ ] Recurrent bladder/urinary tract infections  [ ] Muscle cramps in legs/feet  [ ] Constipation
[ ] Menstrual irregularities/ cramping  [ ] Diarrhea  [ ] Sexual dysfunction  [ ] Scoliosis

FAMILY HEALTH HISTORY:
Have any of your biological family members ever been diagnosed with the following:
[ ] Mental Health Disease  [ ] Neurological Problems  [ ] Lung Disease  [ ] Thyroid  [ ] Arthritis
[ ] Circulatory Problems  [ ] Heart Murmur  [ ] Cancer  [ ] High Blood Pressure  [ ] Heart Disease
[ ] Stroke  [ ] Diabetes  [ ] Scoliosis  [ ] Kidney Disease  [ ] Migraine Headaches

RADIOGRAPHY CONSENT:
In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Virginia Family Chiropractic PM, PLLC to take spine and other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

___________________________________________________  ________________________
Signature of Patient/or Guardian  Date
We provide you with the same information your insurance gives our billing coordinator. If you have any additional questions regarding your benefits or coverage, please contact your insurance carrier directly.

**Co-payments** are to be made at EACH visit. If you have a **co-insurance**, you will pay a portion at the time of each visit. For example if your portion is 10%, you would pay $10 each visit; 20%, you would pay $20 and so on. You may owe an additional amount which we will collect once your claim has been processed.

Patients that have **deductibles** will be responsible for the contracted rate of your treatment per visit until the deductible has been met. This payment will be applied to your deductible once we receive an explanation of benefits from your insurance carrier. You may owe an additional amount which we will collect once all insurance payments have been applied, or have a credit depending on the claim processing.

**Referrals:** Insurance companies (HMO’s) sometimes require their members to obtain a referral from their primary care doctor before seeing a specialist such as a chiropractor. **It is your responsibility** to obtain a referral if needed, and you must do so prior to your scheduled appointment or you will be forced to reschedule. If a referral is not received, you are financially responsible for any charges incurred for that date of service. Be aware that most referral authorizations are good for a certain number of visits and have an expiration date. If you have any questions about obtaining a referral we will be happy to assist you.

The contracted rate is an estimate we have of what your insurance allows. If you have an outstanding balance we will send you (3) statements. If we do not receive payment by the third which is the final statement, further collection action will take place immediately. Should you have any questions regarding the statement, **PLEASE CALL US IMMEDIATELY** in order to speak with the billing coordinator.

**Returned Checks:** You will be charged a $40 returned check fee if a personal check is returned for nonpayment.

A fee of $25.00 is charged if you do not cancel at least 24 hours prior to your scheduled appointment time or “no-show.”
This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

**Pain Intensity**
1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain comes and goes and is moderate.
4. The pain is fairly severe at the moment.
5. The pain is the worst I can imagine at the moment.

**Sleeping**
1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours sleepless).

**Reading**
1. I can read as much as I want with no neck pain.
2. I can read as much as I want with slight neck pain.
3. I can read as much as I want with moderate neck pain.
4. I cannot read as much as I want because of moderate neck pain.
5. I cannot read at all because of severe neck pain.

**Concentration**
1. I can concentrate fully when I want with no difficulty.
2. I can concentrate fully when I want with slight difficulty.
3. I have a fair degree of difficulty concentrating when I want.
4. I have a lot of difficulty concentrating when I want.
5. I have a great deal of difficulty concentrating when I want.
6. I cannot concentrate at all.

**Personal Care**
1. I can look after myself normally without causing extra pain.
2. I can look after myself normally but it causes extra pain.
3. It is painful to look after myself and I am slow and careful.
4. I need someone to help me most of the time.
5. I do not get dressed, I wash with difficulty and stay in bed.

**Lifting**
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights.
6. I cannot lift or carry anything at all.

**Driving**
1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight neck pain.
3. I can drive my car as long as I want with moderate neck pain.
4. I cannot drive my car as long as I want because of moderate neck pain.
5. I cannot drive my car at all because of severe neck pain.

**Recreation**
1. I am able to engage in all my recreation activities without neck pain.
2. I am able to engage in all my usual recreation activities with some neck pain.
3. I am able to engage in most but not all my usual recreation activities because of neck pain.
4. I am only able to engage in a few of my usual recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

**Work**
1. I can do as much work as I want.
2. I can only do my usual work but no more.
3. I can only do most of my usual work but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

**Headaches**
1. I have no headaches at all.
2. I have slight headaches which come infrequently.
3. I have moderate headaches which come infrequently.
4. I have moderate headaches which come frequently.
5. I have severe headaches which come frequently.
6. I have headaches almost all the time.

Index Score = \[rac{\text{Sum of all statements selected}}{\# \text{ of sections with a statement selected} \times 5} \] \times 100
This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

**Pain Intensity**

① The pain comes and goes and is very mild.
② The pain is mild and does not vary much.
③ The pain comes and goes and is moderate.
④ The pain comes and goes and does not vary much.
⑤ The pain is very severe and does not vary much.

**Personal Care**

① I do not have to change my way of washing or dressing in order to avoid pain.
② I do not normally change my way of washing or dressing even though it causes some pain.
③ Washing and dressing increases the pain but I manage not to change my way of doing it.
④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
⑤ Because of the pain I am unable to do some washing and dressing without help.

**Sleeping**

① I get no pain in bed.
② I get pain in bed but it does not prevent me from sleeping well.
③ Because of pain my normal sleep is reduced by less than 25%.
④ Because of pain my normal sleep is reduced by less than 50%.
⑤ Because of pain my normal sleep is reduced by less than 75%.
⑥ Pain prevents me from sleeping at all.

**Lifting**

① I can lift heavy weights without extra pain.
② I can lift heavy weights but it causes extra pain.
③ Pain prevents me from lifting heavy weights off the floor.
④ Pain prevents me from lifting heavy weights if they are conveniently positioned (e.g., on a table).
⑤ Pain prevents me from lifting heavy weights off the floor. I can only lift very light weights.

**Sitting**

① I can sit in any chair as long as I like.
② I can only sit in my favorite chair as long as I like.
③ Pain prevents me from sitting more than 1 hour.
④ Pain prevents me from sitting more than 1/2 hour.
⑤ Pain prevents me from sitting more than 10 minutes.
⑥ I avoid sitting because it increases pain immediately.

**Traveling**

① I get no pain while traveling.
② I get some pain while traveling but none of my usual forms of travel make it worse.
③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
④ I get extra pain while traveling which causes me to seek alternate forms of travel.
⑤ Pain restricts all forms of travel except that done while lying down.
⑥ Pain restricts all forms of travel.

**Standing**

① I can stand as long as I want without pain.
② I have some pain while standing but it does not increase with time.
③ I cannot stand for longer than 1 hour without increasing pain.
④ I cannot stand for longer than 1/2 hour without increasing pain.
⑤ I cannot stand for longer than 10 minutes without increasing pain.
⑥ I avoid standing because it increases pain immediately.

**Social Life**

① My social life is normal and gives me no extra pain.
② My social life is normal but increases the degree of pain.
③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
④ Pain has restricted my social life and I do not go out very often.
⑤ Pain has restricted my social life to my home.
⑥ I have hardly any social life because of the pain.

**Walking**

① I have no pain while walking.
② I have some pain while walking but it doesn't increase with distance.
③ I cannot walk more than 1 mile without increasing pain.
④ I cannot walk more than 1/2 mile without increasing pain.
⑤ I cannot walk more than 1/4 mile without increasing pain.
⑥ I cannot walk at all without increasing pain.

**Changing degree of pain**

① My pain is rapidly getting better.
② My pain fluctuates but overall is definitely getting better.
③ My pain seems to be getting better but improvement is slow.
④ My pain is neither getting better or worse.
⑤ My pain is gradually worsening.
⑥ My pain is rapidly worsening.

\[
\text{Index Score} = \left(\frac{\text{Sum of all statements selected}}{\text{(# of sections with a statement selected x 5)}}\right) \times 100
\]
### Patient History Review of Systems

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>MUSCULOSKELETAL</th>
<th>NEUROLOGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent weight gain</td>
<td>Arthritis</td>
<td>Lightheaded/dizzy</td>
</tr>
<tr>
<td>Recent weight loss</td>
<td>Rheumatoid arthritis</td>
<td>Memory loss</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Broken bones</td>
<td>Headaches</td>
</tr>
<tr>
<td>Fever</td>
<td>Osteoporosis</td>
<td>Migraines</td>
</tr>
<tr>
<td>Allergies</td>
<td>Gout</td>
<td>Numbness</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Scoliosis</td>
<td>Weakness</td>
</tr>
<tr>
<td>Chills</td>
<td>Spinal trauma</td>
<td>Stroke</td>
</tr>
<tr>
<td>Cancer of any kind</td>
<td>Joint pain (anywhere)</td>
<td>Tingling/Numbess</td>
</tr>
<tr>
<td><strong>CARDIOVASCULAR</strong></td>
<td><strong>RESPIRATORY</strong></td>
<td><strong>INTEGUMENTARY (SKIN)</strong></td>
</tr>
<tr>
<td>Heart attack</td>
<td>Coughing</td>
<td>Bruise easily</td>
</tr>
<tr>
<td>Swelling of ankles</td>
<td>Coughing up blood</td>
<td>Skin rashes</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Chronic cough</td>
<td>Discoloration</td>
</tr>
<tr>
<td>Low blood pressure</td>
<td>Chest pain</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Asthma</td>
<td>Changes in moles</td>
</tr>
<tr>
<td>Pain down left arm</td>
<td>Pneumonia</td>
<td>Sores</td>
</tr>
<tr>
<td>Profuse sweating</td>
<td>Bronchitis</td>
<td>Scars</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>Tuberculosis</td>
<td>Itching</td>
</tr>
<tr>
<td><strong>EYES, EARS NOSE &amp; THROAT</strong></td>
<td><strong>GASTROINTESTINAL</strong></td>
<td><strong>GENITOURINARY</strong></td>
</tr>
<tr>
<td>Blurred vision</td>
<td>Gall bladder problems</td>
<td>Painful urination</td>
</tr>
<tr>
<td>Double vision</td>
<td>Liver problems</td>
<td>Blood in urine</td>
</tr>
<tr>
<td>Ear pain</td>
<td>Pain over stomach</td>
<td>Frequent urination</td>
</tr>
<tr>
<td>Hoarseness</td>
<td>Ulcers</td>
<td>Kidney infection</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>Colitis</td>
<td>Kidney stones</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Hiatal hernia</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Dental problems</td>
<td>Blood in stool</td>
<td></td>
</tr>
</tbody>
</table>

**OTHER/EXPLANATIONS:**

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**SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.**
Waiver & Release of Records Practice

ALEXANDRIA
5130 Duke St Suite 114
Alexandria, VA 22304
P: (703) 370-5300
F: (703) 370-0080

WOODBRIDGE
14904 Jefferson Davis Hwy. Suite 301
Woodbridge, VA 22191
P: (703) 499-8840
F: (703) 499-8842

FALLS CHURCH
140 Little Falls Street Suite 101
Falls Church, VA 22046
P: (703) 538-3830
F: (703) 538-3831

MANASSAS
8420 Dorsey Circle Suite 101
Manassas, VA 20110
P: (703) 367-7878
F: (703) 367-0009

For automobile collision patients with health insurance:

I, _________________, patient, undersigned, hereby waive my health insurance benefits for chiropractic care that I receive from Virginia Family Chiropractic & PM for the injuries I suffered in an automobile collision on ________________. In a circumstance which there is no payment from the patients’ car insurance company and/or third party, then we will be billing the health insurance carrier.

PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

DATE OF BIRTH

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

DATE

PATIENT RELEASE OF RECORDS

I hereby authorize the release of my:

☐ X-RAY/MRI/CT SCAN reports, dated ________________________________

☐ ER records, dated ________________________________

☐ MEDICAL records, dated ________________________________

☐ FILMS or documents, dated ________________________________

Send by fax or mail to the above address.

PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

DATE OF BIRTH

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

DATE

The release shall be effective for term of not less than five (5) years from the date of the execution.