

8303 Arlington Blvd., Suite 202
P: 703-573-4773

Fairfax, VA
F: 703-573-2552

22031
E: info@oc-rc.com

Today's date:	PCP:
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PATIENT INFORMATION

LAST NAME:	FIRST:	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Wid / Sep /
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Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Social Security no.:	Home phone no.:
City:	State:	Cell phone no.:
Occupation:	Employer:	Work phone no.:

Email address:

Spouse's name:	Spouse's occupation:	Spouse's employer:
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Referred to clinic by (please check one and specify):

<input type="checkbox"/> Dr.:	<input type="checkbox"/> Close to home/work:
<input type="checkbox"/> Family member:	<input type="checkbox"/> Other:
<input type="checkbox"/> Friend:	Other family members seen here:

IN CASE OF EMERGENCY

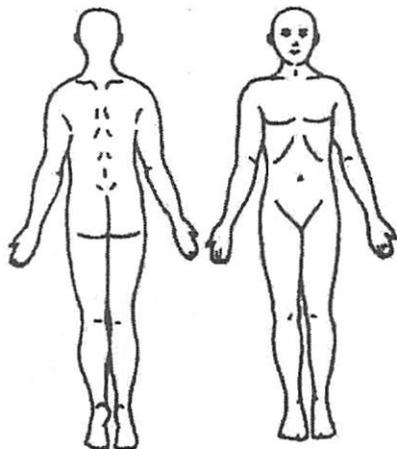
Name of local friend or relative (not living at same address):	Relationship to patient:	Phone No. : ()
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INSURANCE INFORMATION

Name of Insurance Company:		
Name as it is written on card:	Date of Birth:	
Membership ID Number:		
Group Number:		
Enrollment Code (if applicable):		
Provider/Claims Phone Number (back of card):		
Are you the Policy Holder? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO , Name of Policy Holder:	Policy Holder's Date of Birth:

PATIENT CHIEF COMPLAINTS

Please mark the location of your pain.



Please list your current symptoms and on a scale of 0 – 10 (with 0 being no pain and 10 being the worst) how would you rate your pain?

Complaint 1: _____ Date it began: _____

0 1 2 3 4 5 6 7 8 9 10

Complaint 2: _____ Date it began: _____

0 1 2 3 4 5 6 7 8 9 10

Complaint 3: _____ Date it began: _____

0 1 2 3 4 5 6 7 8 9 10

Complaint 4: _____ Date it began: _____

0 1 2 3 4 5 6 7 8 9 10

Have you seen any other physicians for any of the above condition(s)? Yes No

If YES, please explain:

Have you ever been under chiropractic care?

Yes No

When? How long were you treated?

Medications you are currently taking for your condition(s) (please list) :

Do you experience pain every day? YES NO

Do your symptoms interfere with everyday life? YES NO

Does pain wake you up at night? YES NO

Are your symptoms worse during certain times of the day? YES NO

Do changes in weather affect your symptoms? YES NO

Do you wear orthotics? YES NO

ACTIVITIES OF DAILY LIVING

Please list any work related, personal, and/or recreational activities that are affected by your condition:

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PAST MEDICAL HISTORY

Have you been treated for any conditions this last year? Yes No If yes, please describe:

Date of last physical exam: / /	Women: Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had x-rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, where:
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Please circle any conditions you have or have had:

- | | | | | |
|-----------------------|-----------------------|----------------------|------------------------|-------------------------|
| Allergies | Cold extremities | Frequent urination | Loss of smell | Prostate trouble |
| Anemia | Constipation | Headache/migraines | Loss of taste | Sciatica |
| Arteriosclerosis | Chicken Pox | Hemorrhoids | Lumps in breast | Scoliosis |
| Arthritis | Depression | Hot flashes | Mental disorders | Shortness of breath |
| Asthma | Diabetes | High blood pressure | Mumps | Sleep problems/insomnia |
| Back pain | Digestion Problems | Influenza | Neck pain or stiffness | Spinal curvatures |
| Bronchitis | Dizziness | Irregular heart beat | Nervousness | Stroke |
| Bruise easily | Eczema | Kidney infection | Pacemaker | Swollen joints |
| Cancer | Epilepsy | Kidney stones | Pleurisy | Thyroid condition |
| Chest pain/conditions | Eye Pain/difficulties | Loss of balance | Polio | Tuberculosis |
| Cramps | Fatigue | Loss of memory | Pneumonia | Ulcers |

For women only:

Date of last period: _____ Are you pregnant? Yes No

Are there any other conditions we should be aware of? _____

Have you ever:	Explanation/Dates of Treatment
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Broken bones?	<input type="checkbox"/> NO <input type="checkbox"/> YES	
Any previous auto accidents?	<input type="checkbox"/> NO <input type="checkbox"/> YES	
Previous sprains/strains?	<input type="checkbox"/> NO <input type="checkbox"/> YES	

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The information provided above was completed correctly and is true to the best of my knowledge. I understand it is my responsibility to inform the office of any changes to the information I have provided. I authorize Optimal Chiro-Rehab Center to treat my condition as they deem appropriate and to perform any necessary services needed during diagnoses and treatment.

Signature of patient or legal guardian: _____

Date: _____

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Patient Name: _____

Responsible Party Name: _____

Relationship to Patient: _____

Payment for the patient's portion of medical services is due at the time the service is rendered. Our office is happy to verify your insurance benefits for you. Insurance estimates are provided as a courtesy, however, they are **estimates**. Our office will process your insurance claim for you, but in the event that your insurance carrier pays less than the estimated amount, then you, the patient or guarantor, are responsible for the full unpaid balance. We accept cash, checks, and credit cards for your convenience.

Our staff will do their best in going over your treatment and answer any questions relating to your insurance. Please understand:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. **It is the patient's responsibility to review and know their policy and its limitations, as it is an agreement between you (the patient) and your insurance company.**
3. Our fees are considered usual, customary and reasonable and fall within the acceptable range for most medical insurance companies and our demographic area.

We must emphasize that as health providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

- **Missed/Broken Appointment:** There is a \$25 cancellation fee for time reserved for appointments missed, broken, or cancelled without 24-hours advanced notice given.
- **Checks Returned:** There is a \$50 charge for check returns and non-sufficient funds per incident.
- **Finance Charge/Collection Fees:** Over 30 day balances are subject to a 1% interest rate per month, 12% per year charge on your account. You agree to pay our reasonable attorney's fees incurred in the collection of any overdue balances and consent to Fairfax County as the exclusive venue for any litigation arising out of this agreement.

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_____ I understand and agree that, regardless of my insurance status, **I am ultimately responsible for the balance of my account for all health services rendered.** In the event that an insurance company obligated by contractual agreement to make payment upon demand by you, or does not make payment within sixty (60) days from the date of your billing, I become personally responsible for payment of that amount. I will have thirty (30) days following notification by your office to clear the account by contacting my insurance company. If the account has not cleared within the allotted thirty (30) days, I hereby authorize you to charge any outstanding amount on the credit card account listed below.

_____ I will promptly **bring in any insurance checks that I receive to the office. If I fail to do so within five (5) business days of receiving the checks, I authorize charges to my credit card for the amount of the checks.** I also understand agree that **if checks are lost or damaged I am personally responsible for payment**

_____ I understand that I can be charged **\$25.00** if I fail to provide 24-hour notice for appointment cancellations and/or frequent abuse of scheduled appointments, and charged **\$50.00** for all returned checks or non-sufficient funds transactions.

_____ I understand that it is my responsibility to inform this office of any **address or contact phone number changes** on my account.

_____ I authorize this office to **release information relating to my medical care to my insurance company. I desire that medical insurance check payments to be sent directly to the doctor.**

_____ I agree to pay our reasonable **attorney's fees incurred in the collection of any overdue balances and consent to Fairfax County as the exclusive venue for any litigation arising out of this agreement.**

<p>_____ I hereby authorize Optimal Chiro-Rehab Center and its agents to bill my credit card for charges incurred by me.</p> <p>Print Name (as it appears on card): _____</p> <p>Billing address: _____</p> <p>_____</p> <p>CC#: _____</p> <p>Expiration date: _____ CID #: _____</p>
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I authorize and give consent for medical treatment of the person named above and agree to pay all fees and charges for such treatment and services rendered. In the case it is treatment for a minor, I agree as the parent and/or legal guardian of the minor receiving medical care at this office, I am ultimately responsible for all payments of fees for medical services rendered to the minor in my care.

Printed name: _____

Signature: _____ Date: _____

Please initial and sign:

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
- b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

Chiropractic treatment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

Licensed acupuncturists are encouraged to advise patients that there are or may be some risks associated with such treatment:

- a) Acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days. Dizziness and fainting may occur, in particular if the patient is dehydrated or has a tendency to skip meals. Infection is another possible risk although the clinic uses disposable needles and maintains a clean and safe environment. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).
- b) Cupping, another method of treatment, has the common side effect of bruising.
- c) Electrical Stimulation side effects may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment

Most side effects disappear within 48 hours; however results may vary depending on the patient's age and overall health.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic and acupuncture treatments. I state that I have been informed and weighed the risks involved in treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

Patient Signature (Legal Guardian): _____

Name: _____
(Please print)

Date: _____

NOTICE OF PRIVACY POLICY

EFFECTIVE DATE: SEPTEMBER 13TH 2013

Optimal Chiro-Rehab Center is committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices.

This form is to acknowledge that you have received for your records our Notice of Privacy Policy. The Policy handed to you covers the following:

**Your Personal Health Information
Uses or Disclosures of Your Personal Health Information
Your Rights With Respect to Your Personal Health Information
Complaints
On-going Access to Privacy Policy
Amendments to this Privacy Policy**

I have received a copy of the above mentioned Notice of Privacy Policy.

Name: _____ Date: _____
(Patient or Legal Guardian)

Signature: _____ Date: _____
(Patient or Legal Guardian)

PATIENT FUNCTIONAL ASSESSMENT QUESTIONNAIRE

PATIENT NAME: _____

DATE: _____

INSTRUCTIONS: Circle the level of difficulty for each activity.		0 = Absolute no difficulty	1 = Able to do w little difficulty	2 = Able to do w lit-mod difficulty	3 = Able to do w mod difficulty	4 = Able to do w mod-signif difficulty	5 = Able to do w signif difficulty	6 = Unable to do at all	Not applicable
MOBILITY/WALKING	1 Walking short distances	0	1	2	3	4	5	6	n/a
	2 Walking long distances	0	1	2	3	4	5	6	n/a
	3 Walking outdoors	0	1	2	3	4	5	6	n/a
	4 Climbing stairs	0	1	2	3	4	5	6	n/a
	5 Hopping	0	1	2	3	4	5	6	n/a
	6 Running	0	1	2	3	4	5	6	n/a
CHANGE/MAINTAIN BODY POSITION	1 Rolling over	0	1	2	3	4	5	6	n/a
	2 Moving - lying to sitting	0	1	2	3	4	5	6	n/a
	3 Sitting	0	1	2	3	4	5	6	n/a
	4 Bending/Stooping	0	1	2	3	4	5	6	n/a
	5 Kneeling	0	1	2	3	4	5	6	n/a
	6 Standing	0	1	2	3	4	5	6	n/a
CARRY/MOVE/ HANDLE OBJECTS	1 Pushing	0	1	2	3	4	5	6	n/a
	2 Pulling	0	1	2	3	4	5	6	n/a
	3 Reaching	0	1	2	3	4	5	6	n/a
	4 Grasping	0	1	2	3	4	5	6	n/a
	5 Lifting	0	1	2	3	4	5	6	n/a
	6 Carrying	0	1	2	3	4	5	6	n/a
SELF CARE	1 Dressing/Clasp b/h back	0	1	2	3	4	5	6	n/a
	2 Doing light housework	0	1	2	3	4	5	6	n/a
	3 Prep meals/kitchen tasks	0	1	2	3	4	5	6	n/a
	4 Bathroom activities	0	1	2	3	4	5	6	n/a
	5 Sleeping Ability	0	1	2	3	4	5	6	n/a
	6 Hygiene (comb hair/brush teeth)	0	1	2	3	4	5	6	n/a

PATIENT SIGNATURE

DATE

REVIEWED BY THERAPIST / CREDENTIALS

DATE