GOLD
CHIROPRACTIC & SPORTS RECOVERY

e: info@goldchiropracticsports.com
p: 703-942-8828
f: 703-942-8829

8206 Leesburg Pike Suite 309
Vienna VA 22182

PATIENT INFORMATION

Name: ____

Address: ______________________________________

City: ____

State: ______ Zip: _________

Sex: ☐ Male ☐ Female Age:_____

Date of Birth: ____/____/_______

Phone #: Home- ___________________________

Cell- ___________________________

Work- ___________________________

Email: __________________________@______.______

Employer: _____________________________________

Occupation: ____________________________________

How did you hear about us? :

____

Have you ever been to a chiropractor before?:☐ yes ☐ no

Primary Doctor: ___________________________

Phone: __________________________________

EMERGENCY CONTACT:

Name: ______________________________

Phone: ______________________________

INSURANCE INFORMATION

Insurance Co: ________________________________

Policy ID#: __________________________________

Group #: ____________________________________

Subscriber's name: ____________________________

Relationship to patient:
☐ Self ☐ Spouse ☐ Child ☐ Other: ________

Subscriber Date of Birth: ____/____/_______

Subscriber Address: ____________________________

City: ______________________________

State: ______ Zip: _________

Is there a secondary health insurance?:
☐ yes ☐ no If yes, please list: _____________________

Is this related to auto or work injury?: ☐ yes ☐ no

Please allow our staff to photocopy your driver's license and insurance card. All information is confidential.

HIPAA INFORMATION

I have read and understood the "Notice of Privacy Practices" for Gold Chiropractic and Sports Recovery.I understand that if I have any questions regarding this policy I may ask the doctor.

I authorize the office to contact me at:
☐ home ☐ work ☐cell
We may leave message at:
☐ home ☐ work ☐ cell.

Signature: ______________________________

Date: ______________

ASSIGNMENT OF BENEFITS

I (______________________________) hereby instruct and direct my insurance company (______________________) to pay by check or electronic funds transfer (EFT) made out to **Gold Chiropractic and Sports Recovery.** For the professional or medical expense benefits allowed and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment. (1: a photocopy of this assignment shall be considered as effective and valid as the original; 2: I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case; 3: I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf) I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered as per the financial policy. A copy of this financial policy will be furnished on request.

Signature: ______________________________________ Date: _______________

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► What is your **current complaint**?:

____
____
____

► My current complaint is a result of ____

► When was the **onset** of this problem?: ____________________________ ☐ gradual ☐ sudden

► Since the onset, has the problem been getting **better, getting worse,** or **not changing**?: _________________________

► How frequently does this bother you?: ☐ constant (76-100% of the day) ☐ frequent (51-75% of the day) ☐ occasional (26-50% of the day) ☐ intermittent (0-25% of the day)

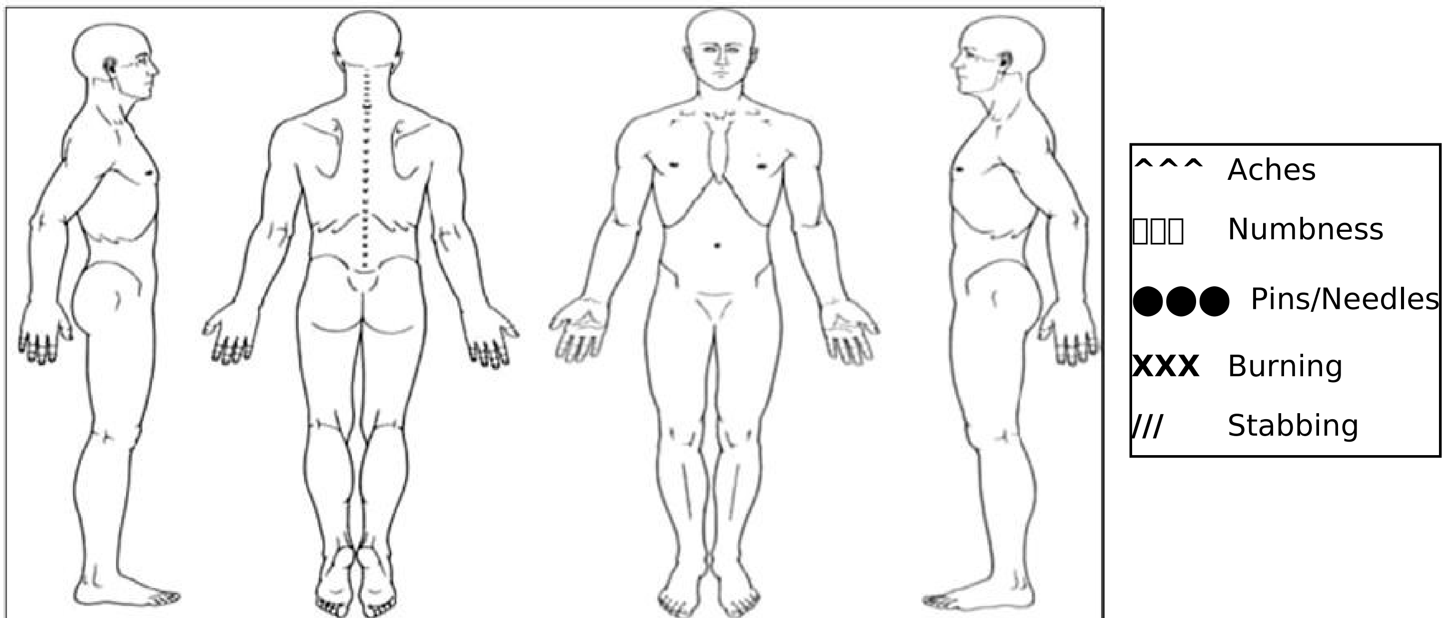
► On a scale of 0-10, (with 10 being the most painful and 0 being no pain at all), how would you **rate your pain**?

0	1	2	3	4	**5**	6	7	8	9	**10**
(no pain)					**(moderate pain)**					**(severe pain)**

► How would you describe the **quality** of the symptoms you are experiencing?:
☐ numbness ☐ tingling ☐ stiffness ☐ dull ☐ aching ☐ cramping ☐ other: ______________
☐ nagging ☐ sharp ☐ burning ☐ shooting ☐ throbbing ☐ stabbing

► Radiation: does it affect other areas of your body? If so, where does it radiate? _______________________________________

► Location: please mark the body diagram where you are experiencing your current symptoms, using the appropriate symbols.



► **Aggravating factors**: what tends to worsen the problem or increase pain?: ____

► **Relieving factors**: what tends to lessen the problem or decrease pain?: ____

► Have you had **any other treatment** for this complaint?: ☐ yes ☐ no
If yes, please check which treatment:
☐ prescription medication ☐ OTC drugs ☐ homeopathic remedies ☐ massage
☐ physical therapy ☐ surgery ☐ acupuncture ☐ chiropractic

► Is the problem worse at a certain **time of day**?: ☐ morning ☐ midday ☐ night ☐ comes and goes

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Employment, Activities of Daily Living, and Recreation Information:

► Description of work: ____

► Condition's effect on work: ☐ no effect (no pain, can perform) ☐ mild effect (painful, can do) ☐ moderate (painful, limited ability) ☐ severe (painful, cannot perform)

Daily Activities: Effects of Current Condition on Performance

► Place an (X) in the box of those that apply:

	No effect	Mild (painful, can do)	Moderate (painful, limited)	Severe (cannot perform)
Bending				
Self care				
Carrying Groceries				
Sitting to Standing				
Climbing Stairs				
Driving				
Extended Computer Use				
Feeding				
Household Chores				
Kneeling				
Lift Children				
Lifting				
Pet Care				
Reading				
Bathing				
Dressing				
Shaving				
Sleeping				
Sitting				
Standing				
Walking				
Yard work				

► **Medical Conditions**: check all that apply to you

☐ arthritis ☐ cancer ☐ diabetes ☐ heart disease ☐ hypertension ☐ psychiatric illness
☐ skin disorder ☐ stroke ☐ headaches ☐ multiple sclerosis ☐ epilepsy ☐ gout
☐ hepatitis ☐ HIV/AIDS ☐ tuberculosis ☐ GI problems ☐ ulcer ☐ immune disorders
☐ osteoporosis ☐ scoliosis ☐ neck pain ☐ back pain ☐ hip pain ☐ knee pain
☐ foot pain ☐ shoulder pain ☐ TMJ pain ☐ anxiety ☐ depression ☐ blood disorder
☐ dizziness ☐ numbness ☐ bruising ☐ high cholesterol ☐ asthma ☐ emphysema
☐ pneumonia ☐ blurred vision ☐ hearing loss ☐ aortic aneurysm ☐ eczema ☐ low energy
☐ kidney stones ☐ fainting ☐ fatigue ☐ sudden weight change ☐ psoriasis
☐ other: ____________________

► **Surgeries**: please list all surgeries and hospitalizations ☐ spine ☐ pacemaker ☐ other:

____
____

► **Injuries**: please list any significant traumas or accidents you have had in your lifetime

____
____

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► **Allergies**: please list any allergies you may have, and your reaction to the allergen

____
____

► **Social History**: check all that apply to you

Caffeine Use:	☐ daily	☐ weekly	☐ occasionally	☐ never
Alcohol Use:	☐ daily	☐ weekly	☐ occasionally	☐ never
Tobacco Use:	☐ daily	☐ weekly	☐ occasionally	☐ never
Exercise:	☐ daily	☐ weekly	☐ occasionally	☐ never
Pain Relievers:	☐ daily	☐ weekly	☐ occasionally	☐ never

► **Family History**: check all that apply

☐ Arthritis ☐ Diabetes ☐ Heart disease ☐ Thyroid ☐ Depression ☐ Multiple Sclerosis
☐ Cancer ☐ Stroke ☐ Hypertension ☐ Autoimmune ☐ Other: ______________________________

► **Medications/Supplements**: please list all medications or supplements you currently take, and the reason for taking them.

____
____
____
____

► **Imaging**: have you had any recent x-rays, MRI's, or CT scans?: ☐ yes ☐ no if yes, of what? ______________________________

► Are there any other personal health or hereditary issues Gold Chiropractic and Sports Recovery should know about? ____
____

► What **specific goals** would you like to accomplish with chiropractic treatment? (i.e. walking / running without pain, sitting comfortably, do your job without pain, etc..)

____
____

Acknowledgements

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_______ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity

_______ I may request a copy of the Privacy Policy and understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_______ 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 care in this office.

_______ I acknowledge that any insurance I may have in an agreement between the carrier and me that I am responsible for the payment of any covered or non-covered services I receive.

_______ I understand there is a 24 hour no show/cancellation policy and I will be charged $30 if I don't provide proper notice of cancellation via email/voice mail/office call.

_______ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

If patient is a **minor**, print child's full name: ____

____ ______________________

Patient Signature **Date** (MM/DD/YYYY)