



Skyline Wellness Center
4218 King Street
Alexandria, VA 22313
(703) 879-5144
fax (703) 879-5860
www.skylinewellnesscenter.com

Personal Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ___/___/___ Age: ___ Sex: M F Height: _____ Weight: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

SSN: _____ E-Mail: _____ Occupation: _____

Choose One: Married Engaged Single Partnered Divorced Widowed # of Kids: _____

How did you hear about our Clinic: _____

Current Health Condition

Major Complaint: _____

Cause: Insidious Auto Accident Fall Work Injury Sport Injury Other: _____

What was the mechanism of injury? _____

Pain Level NOW: No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Pain at its WORST: No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

When did this condition begin? _____

What percentage of the day does it bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

When does it bother you the most? AM MID DAY PM ALL DAY NIGHT

What worsens condition? _____

What offers relief? _____

How does it affect your Daily/Recreational Activities? _____

Other Doctors seen for this Condition: _____

Have you ever received Massage Therapy? Y N If yes, what type: _____

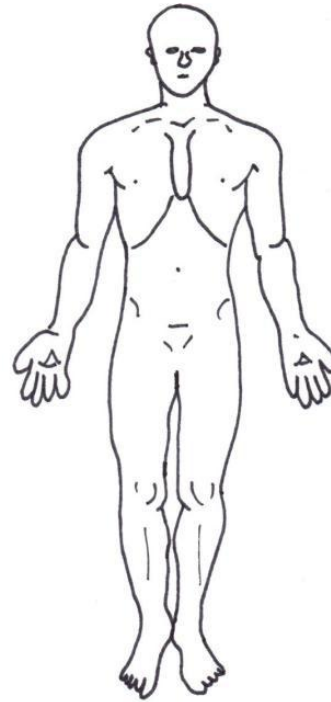
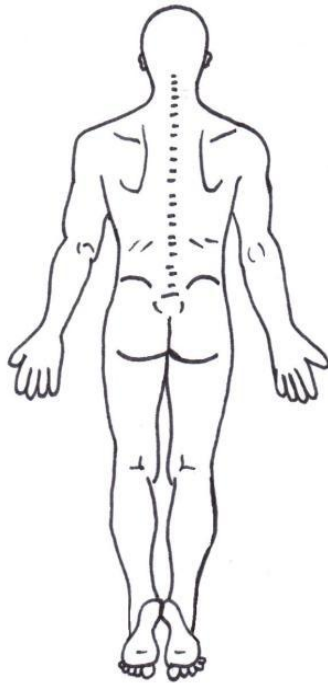
Do you have any of the following today? Skin rash Cold/Flu Open Cuts/Bruises

Please list any allergies: _____

Are you wearing: Contact Lenses Hearing Aid Hairpiece Pacemaker

Please indicate any areas in which you are feeling discomfort/pain. Use the following letters to indicate what TYPE of sensation you are feeling in that area:

A=Ache B=Burning P=Pins and Needles S=Stabbing N=Numbness O=Other



Current Medications

- Pain Relievers Anti-Inflammatory Muscle Relaxants Aspirin (or similar)
 Blood Pressure Insulin Thyroid Anti-Depressant Birth Control
 Other: _____

Past Health History

- Major Surgery? Back Neck Heart Gall Bladder Hernia Appendectomy
 Female/Male Surgery Rectal Sinus/Rhinoplasty Thyroid Stomach
 Cancer: _____ If so, when: _____

Major Accidents/Falls/Hospitalizations: _____

Previous Chiropractic Care (Dr. name and last visit): _____

Been treated for any health condition in the past year? No Yes: _____

Below is a list of conditions which may affect your overall diagnosis, treatment plan and the possibility of being accepted for care. Please check off the following signs/symptoms that apply:

General Symptoms

- Headaches
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Loss of Weight
- Arm/Hand Numb
- Arm/Hand Pain
- Leg/Foot Numb
- Leg/Foot Pain
- Neuralgia

Gastro-Intestinal

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Stomach Pain
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids
- Liver Trouble
- Jaundice
- Gall Bladder Prob.
- Rectal Bleeding

Eye/Ear/Nose/Throat

- Poor Vision
- Crossed Eyes
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Ear Discharges
- Nasal Obstruction
- Nose Bleeds
- Sore Throat
- Hoarseness
- Asthma/Wheezing
- Frequent Colds
- Thyroid Problems
- Tonsillitis
- Sinus Trouble

Respiratory

- Chronic Cough
- Spitting Blood
- Spitting Phlegm
- Chest Pain
- Difficulty Breathing

Genito-Urinary

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infection
- Kidney Stones
- Bed Wetting
- Urine Control Prob.
- Prostate Trouble

Muscles & Joints

- Weakness
- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Tremors
- Painful Tailbone
- Mid/Upper Back Pain
- Hernia
- Spinal Curvature

Cardio-Vascular

- Rapid Heart Beat
- Slow Heart Beat
- High Blood Press.
- Low Blood Press.
- Pain Over Heart
- Prior Heart Cond.
- Ankle Swelling
- Poor Circulation
- Varicose Veins
- Stroke History

Skin or Allergies

- Skin Eruptions
- Itching
- Bruise Easily
- Dryness
- Boils
- Sensitive Skin
- Hives
- Allergies: _____
- Eczema
- Hay Fever

FOR WOMEN ONLY

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Hot Flashes
- Cramps / Backache
- Miscarriage
- Vaginal Discharge
- Currently Pregnant
- Last PAP Smear
- Date: _____

Have you had any of the following diseases?

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder: _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> MS | <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Lou Gehrig's Disease |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: _____ | | |

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Habits

- Smoking __packs/day
 Alcohol __drinks/day
 Soft Drinks __cans/day
 Coffee __cups/day
 Chocolate __ounces/day

Exercise

- None
 Moderate
 Daily

 (Type of Ex)

Desired Care

Please indicate desired care: Relief Care Corrective Care Comprehensive Care Doctor's Rec.

On a scale of 1 to 10 (10 being highest), how committed are you to correcting the problem? _____

What do you hope to achieve with your care? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself, and are not a guarantee of payment. Furthermore, I understand the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor for x-rays is for examination only, and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

I hereby certify that all of the above information is accurate to the best of my knowledge, and will alert Skyline Wellness Center in the event that any of the information changes.

 Patient Printed Name

 Patient Signature

 Date



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Authorization and Consent for Manipulation or Special Procedures

This clinic maintains personnel and facilities to assist your doctor(s) in the performance of various manipulative procedures and other special diagnostic and therapeutic procedures. These manipulative and ancillary procedures all may involve calculated risks or complication, injury or even death, from both known and unknown causes, and no warranty or guarantee has been made as to the result or cure. Since any risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. Except in emergency or exceptional circumstances, these procedures are therefore not performed upon patients unless and until the patient has the right to consent to or refuse any proposed procedure or therapy (based on the description or explanation received).

Your doctor(s) have determined that the procedures listed below may be beneficial in the diagnosis or treatment of your condition. Upon your authorization and consent, such operations or special procedures can be performed for you by your doctor and/or by other physicians, nurses, and technical staff selected by them.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a chain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Your signature below constitutes your acknowledgement that; (1) You have read and agreed to the foregoing; (2) the procedures and possible alternate means of therapy have been adequately explained to you by your doctor and that you have all of the information you desire; (3) You authorize and consent to the performance of procedures and tests in unforeseen conditions which your doctor or his/her associates or assistants may consider necessary or advisable in the courses of the procedures specified below; (5) No guarantee or cure has been promised to you.

Procedures: Manipulation, Traction, Exercise, Hot Packs, Cryotherapy, Nutrition, Interferential Current, Deep Muscle Therapy

Printed Patient Name

Date

Patient/Guardian Signature

Date

Witness Signature

Date



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Notice/Acceptance of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us.

- (1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
- (2) We are required to abide by the terms of this Notice currently in effect.
- (3) We reserve the right to change the terms of this Notice at any time. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information:

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, and to determining the appropriate treatment for that condition. It may also be necessary to share your information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, general administrative functions, overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization involving public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

- (1)** You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment. We are not required to agree to the restriction; however, if we do, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if required by law to make a full disclosure without restriction.
- (2)** You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- (3)** You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, to include: the cost of copying, postage, and preparation or an explanation or summary of the information.
- (4)** You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- (5)** If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, <http://www.hhs.gov/ocr/hipaa>.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
Meagan Walters, Office Manager. Phone: (703) 879-5144, Fax: (703) 879-5860.

I consent to the use or disclosure of my protected health information by SWC for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of SWC. I understand that analysis, diagnosis or treatment of me by SWC may be conditioned upon my consent as evidenced by my signature below:

Patient Printed Name

Patient Signature

Date