



Skyline Wellness Center
 4218 King Street
 Alexandria, VA 22313
 p: (703) 879-5144
 f: (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: _____
 Choose One: Single Married Partnered Divorced Widowed No. of Children: _____
 How did you hear about our Clinic: _____

Current Health Condition

Major Complaint: _____
 Cause: Insidious Auto Accident Fall Work Injury Sport Injury
 Other: _____
 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 most? AM MID DAY PM ALL DAY NIGHT
 What worsens the condition? _____
 What offers relief? _____
 How does it affect your Daily Activities? _____
 How does it affect your Recreational Activities? _____
 Other Doctors seen for this Condition: _____

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

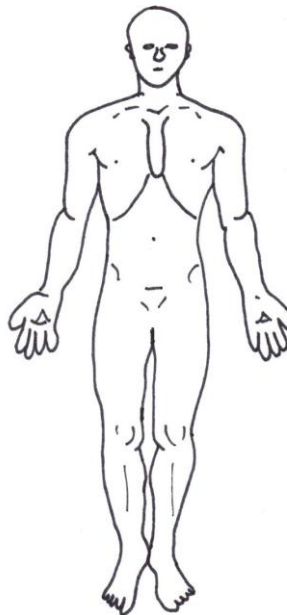
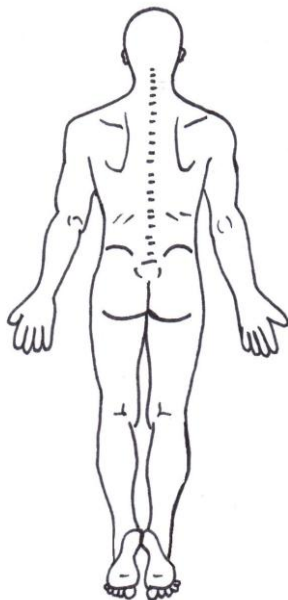
B=Burning

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 Cancer: _____

Major Accidents/Falls/Hospitalizations: _____

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

Have you been treated for any health condition in the past year? Yes No

If yes, please explain: _____

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.

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"/> 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

- | | |
|--------------------------------------|---------------|
| <input type="checkbox"/> Smoking | __ packs/day |
| <input type="checkbox"/> Alcohol | __ drinks/day |
| <input type="checkbox"/> Soft Drinks | __ cans/day |
| <input type="checkbox"/> Coffee | __ cups/day |
| <input type="checkbox"/> Chocolate | __ ounces/day |

Exercise

- | |
|-----------------------------------|
| <input type="checkbox"/> None |
| <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Daily |
| _____ (Types of Exercise) |

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 opposite the procedures 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; (4) No guarantee or a cure has been promised to you.

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

_____	_____
Printed Patient Name	Date
_____	_____
Patient Signature	Date
_____	_____
Parent/Guardian Signature of Minor	Date
_____	_____
Witness Signature	Date



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Acceptance of Privacy Practices

In this document, "I" and "my" refer to patient, and "SWC" refers to Skyline Wellness Center.

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.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. SWC is not required to agree to the restrictions that I may request. However, if SWC agrees to a restriction that I request, the restriction is binding on SWC.

I have the right to revoke this consent, in writing, at any time, except to the extent that SWC has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the "Notice of Privacy Practices of Skyline Wellness Center" and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of SWC. This Notice of Privacy Practices also describes my rights and the duties of the SWC with respect to my protected health information.

SWC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of SWC and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Printed Name

Patient Signature

Date