KING STREET
Chiropractic
Wellness Center

Setting Your Health in Motion

Bradlee Office Building
3543 W. Braddock Road, Suite 200
Alexandria, VA 22302
703.578.1900 office
703.578.0982 fax
www.kingstreetwellness.com
info@kingstreetwellness.com

Welcome to King Street Chiropractic Wellness Center

We look forward to providing you with quality and professional healthcare in our office. The information we gather on the following pages is important to properly assess your symptoms, function, health care challenges and related goals. Please complete them to the best of your ability so that we can get you on the road to health. We look forward to a healthy relationship with you and your family.

PLEASE PRINT Date_____

Name_____ Sex: M – F Birth date _____/____ /_____

Address _____City _____, State_____, Zip_____

Contact numbers Home _____Mobile _____ Cell Carrier _____ Work _____

Which contact above do you prefer we call you when necessary? _____

Email _____ Age_____ Height_____ Weight _____

Check status that applies. ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed No. of children _____

Name of Spouse/Partner/Significant other _____Preferred Language: _____

Ethnicity ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐Decline to respond

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐White (Caucasian)
☐ Native Hawaiian or Pacific Islander ☐Other ☐ Decline to respond

Emergency Contact Name_____Relationship:_____ Phone # _____

Your occupation_____ Employer name_____

Employer address_____City _____, State_____, Zip_____

How did you hear about King Street Chiropractic Wellness Center? _____

☐ Patient Referral ☐ Physician Referral ☐ Ad ☐ Website ☐ Email ☐ Sign ☐ insurance company ☐ Other_____

If referred, whom may we thank for referring you to our office? _____

Check any of these activities that you incorporate into your lifestyle. ☐ massage ☐ healthy eating ☐ acupuncture ☐ jogging
☐ weight training ☐ yoga ☐ dance ☐ sports ☐ walking ☐ meditation ☐ stretching ☐ other activities_____

_____

Have you ever had Chiropractic Care before? ☐ Y or ☐ N If yes, when & by whom _____

Are you pregnant? ☐ Y or ☐ N

REASON FOR TODAY'S VISIT/SYMPTOMS (please be specific)

_____

_____

When did the symptoms first appear? _____ Have you ever had a problem like this before? ☐ Y or ☐ N

Have you seen other doctors / practitioners' for this condition? ☐ Y or ☐ N Drs. Name_____

☐ Primary Care ☐ Chiropractor ☐ Orthopedist ☐ Neurologist ☐ Physical Therapist ☐ Acupuncturist ☐ Massage Therapist

Are you taking medication for this problem? ☐Y or ☐N If yes, what are you taking? _____

_____

What makes your problem worse? ☐ Sitting ☐ Standing ☐ Changing Position ☐ Walking ☐ Bending ☐ Lifting ☐ Twisting ☐ Sex
☐ Driving ☐ Sleeping ☐ Sneeze/Cough ☐ Computer Work ☐ Telephone ☐ Going from sit to stand ☐ Other_____

What makes the symptoms better? _____

Describe your symptoms. ☐ Constant ☐ frequent ☐ Occasional ☐ Mild ☐ Moderate ☐ Severe

Is your condition getting worse? ☐ Y or ☐ N ☐ Don't know

Do your symptoms interfere with ☐ working ☐ sleeping ☐ recreation / hobbies ☐ home life / kids ☐ daily routines ☐ other

Have you had previous spinal surgery? ☐Y or ☐N If yes, when & what area of spine? _____

Have you had x-rays or MRI's for this problem recently? ☐Y or ☐N If yes, when & where_____

Are these symptoms related to a recent automobile accident? ☐ Y or ☐ N

Are these symptoms related to a work injury? ☐ Y or ☐ N If yes, have you reported it to your employer? ☐ Y or ☐ N

SOCIAL HISTORY

Please check (√) all that apply.

☐ never smoked	☐ no exercise	☐ no alcohol	☐ no caffeine
☐ previously smoked	☐ light exercise	☐ beer (amt/day) _____	☐ coffee (amt/day) _____
☐ presently smoke	☐ moderate exercise	☐ wine (amt/day) _____	☐ tea (amt/day) _____
pack/wk _____	☐ heavy exercise	☐ liquor (amt/day) _____	☐ soda (amt/day) _____
years _____	type _____		

Mother ☐ Living ☐ Deceased List any medical problems: _____

Father ☐ Living ☐ Deceased List any medical problems: _____

List any problems common in your family. ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ Arthritis

☐ Scoliosis ☐ Thyroid disease ☐ Osteoporosis ☐ Other _____

PAST MEDICAL HISTORY

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Cancer	☐ Heart Disease	☐ Osteoporosis
☐ Alcoholism	☐ Diabetes	☐ Hepatitis	☐ Other_____
☐ Anemia	☐ Type I	☐ Hernia	☐ Pace Maker
☐ Anorexia	☐ Type II	☐ High Cholesterol	☐ Prostate Problems
☐ Appendicitis	☐ Drug Abuse	☐ High Blood Pressure	☐ Stroke
☐ Arthritis	☐ Emphysema	☐ Kidney Disease	☐ Thyroid Problems
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Tuberculosis
☐ Blood Disorder	☐ Fractures	☐ Migraines	☐ Tumors
☐ Bronchitis	☐ Gout	☐ Multiple Sclerosis	☐ Ulcers

List injuries, hospitalizations, or surgeries	**Date**	**Treatment**
_____	_____	_____
_____	_____	_____
_____	_____	_____

THE PAYMENT METHOD YOU PLAN TO USE TODAY IS

☐ Check ☐ Cash ☐ Credit Card ☐ Insurance

INSURANCE INFORMATION

Primary Insurance Name _____ Phone # _____

Insured's Name_____ Relationship_____ Insured's DOB_____

Member ID# _____ Group #: _____ Effective Date of Coverage _____

Secondary Insurance Name _____ Phone # _____

Insured's Name _____ Relationship _____ Insured's DOB _____

Member ID# _____ Group # _____ Effective Date of Coverage _____

X-RAY CONSENT

I hereby give my consent to King Street Chiropractic Wellness Center and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____
Patient Signature Date

If applicable

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

Signature: _____(parent/Legal Guardian) **Date:** _____

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CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE PRACTICES

I, _____ ,(your name) consent to King Street Chiropractic Wellness Center (KSCWC) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me and for the KSCWC's treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by KSCWC that related to my past, present, or future physical or mental health or condition: the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have a right to request a restriction on the use and disclosure of my Protested Health Information for the purposes of treatment, payment or health care operations of , KSCWC but the KSCWC is not required to agree to these restrictions. However, if KSCWC agrees to a restriction that I request, the restriction is binding to KSCWC.

I understand I have a right to review KSCWC 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy KSCWC describes my rights and KSCWC'S duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physicians or KSCWC has acted in reliance on this consent.

_____
Signature of Patient or Their Personal Representative

_____
Name of Patient or Their Personal Representative (Relationship to Patient)

_____
Date

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OFFICE POLICIES

1. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure payment of benefit. I authorize the use of this signature on all my insurance submissions. If my insurance does not cover the services received then I am financially responsible to pay for them in full.
2. I must pay my deductibles, co-payments and coinsurance at the time of service required by my insurance.
3. I agree to pay for any Returned/Bounced checks from my bank: $35.00 bank fee per check/occurrence.
4. Insurance benefits quoted by my insurance company are NOT a guarantee of my benefits nor payment.
5. If my account is turned to collections, I agree to pay all collection fees, court cost and 33% of attorney fees.
6. I will be charged a $25.00 no-show fee for an appointment not canceled by the time of the appointment.
7. I will be billed the full price of massage appointments cancelled with less than 24 hour notice.
8. King Street Chiropractic Wellness Center is hereby authorized to release any information regarding my physical condition to any insurance company and/or attorney in order to process any claim for reimbursement of charges incurred by me.

Print Name _____ Signature _____ Date _____

CONSENT FOR CARE AND WAIVER

I hereby request and consent to the delivery of physical medicine procedures, including manipulation, massage, spinal manipulation, various modes of physical therapy and diagnostic testing on me (or for the patient I am legally responsible for) by the health providers of King Street Chiropractic Wellness Center. I understand and am informed that there are some risks to treatment, including but not limited to, fractures, disc injuries, stroke, dislocation, and sprains. I do not expect the provider to be able to anticipate and explain all the risks and complications, and I wish to rely on the providers to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts then known, is in my best interest. I have read, or have been read to me, the above consent. I have also or will have the opportunity to ask questions about this consent form, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition in which I seek treatment.

Print Name _____ Signature _____ Date _____

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REVIEW OF SYSTEMS (M.S.Q.)

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	**Energy/Activity:** _____ Fatigue/Sluggishness _____ Apathy/Lethargy _____ Hyperactivity _____ Restlessness	**Lungs:** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness Of Breath _____ Difficulty Breathing
Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage From Ear _____ Ringing In Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety/Fear/Nervousness _____ Anger/Irritability/Aggressiveness _____ Depression	**Digestive Tract:** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred speech	
Mouth & Throat: _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores		**Other:** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints/Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Grand Total:**_____

Subtotal:_____ Subtotal:_____ Subtotal:_____

SYMPTOM DIAGRAM

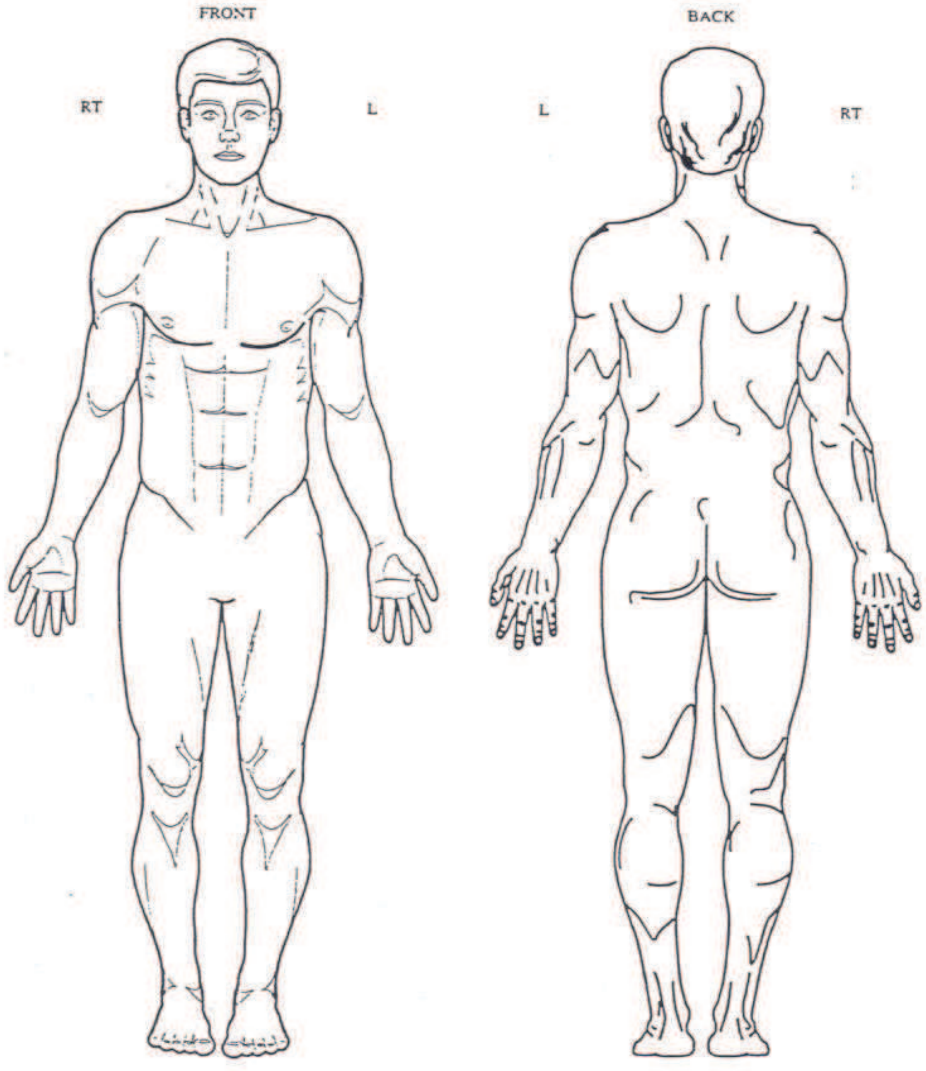
Name_____ Date_____

Step 1. On the diagram, use the designated letter(s) to represent the symptoms you experience.

P=Pain **A**=Achy **S**=Stiffness **T**=Tingling **N**=Numbness **B**=Burning

Step 2. On the diagram, use the designated numbers defined in the box below to represent the intensity of the symptoms you experience.

1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable.



MEDICATION AND DOCTORS LIST

NAME_____ DATE_____

MEDICATIONS

Are you currently taking any blood thinners such as Coumadin, Warfarin, etc.? Yes No

Please list the prescription drugs you are currently taking and the reason for their use

Medication	Reason for use

List any allergies:_____

Please list any vitamins or supplements you are currently taking

_____

_____

_____

Would you be interested if we could help you resolve your current medical condition(s) without the use of medications? Please circle Yes No

If so, please note which conditions or medications.

_____

_____

PHYSICIAN INFORMATION -Please list names and contact information for those applicable to you:

Primary Care Physician _____ Phone_____

Address_____ City_____ State_____ Zip_____

Endocrinologist_____Phone_____

Address_____ City_____ State_____ Zip_____

Cardiologist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Specialists_____ Phone_____

Address_____ City_____ State_____ Zip_____