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

KSC-05-0715

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 pack/wk _____ years _____	☐ moderate exercise	☐ wine (amt/day) _____	☐ tea (amt/day) _____
	☐ heavy exercise type _____	☐ liquor (amt/day) _____	☐ soda (amt/day) _____

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 _____

SYMPTOM DIAGRAM

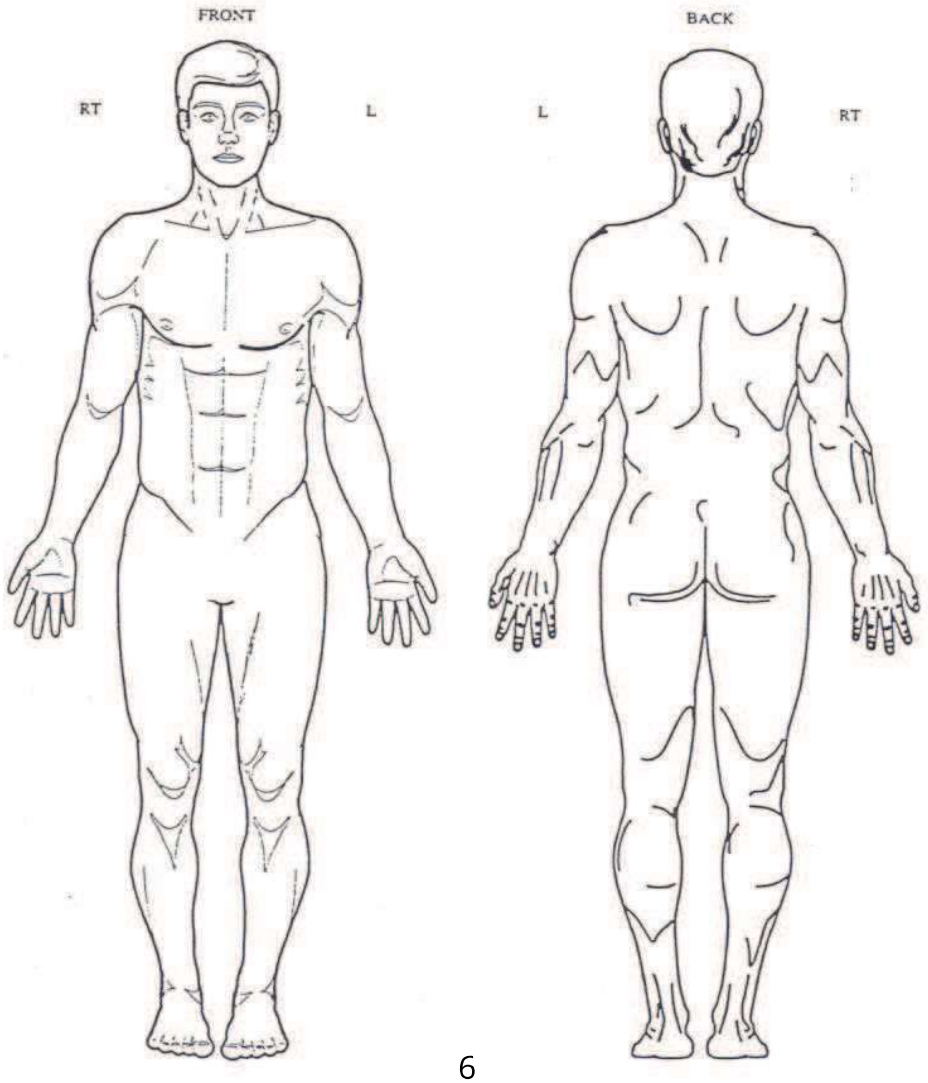
Name_____ Date_____

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_____

KSC-09-0715

King Street Chiropractic Wellness Center
Massage Therapy Agreement & Policies

AGREEMENT
It is my choice to receive Massage Therapy. I realize that massage therapy is not a substitution for other forms of health care and that my Massage Therapist cannot diagnose illness or disease, be it physical or mental. Nor, is my massage therapist able to perform manual adjustments of the skeletal system by use of spinal thrust manipulations. I understand the massage therapy that I receive is being given with the intention of providing relief from muscle pain, muscle spasm, and muscle tension or to increase circulation and/or energy flow. I agree to communicate with my massage therapist if at any time feel like my well being is being compromised.

I have disclosed all medical conditions that I am aware of and agree to keep my massage therapist advised of any changes in my health status.

I, the undersigned, have read and understand the above agreement.

Client Name:_____

Client Signature: _____Date:_____

Massage Center Policies
Inappropriate behavior
I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Inclement Weather
In the event of snow, ice or any other weather condition, we ask that our clients contact us to reconfirm their scheduled appointments. Should the Center close due to weather condition the answering system will reflect the closing. We do not follow school closings.

Tardiness
We realize and respect that our client's time is valuable. It is our goal to start sessions on time. Therefore if you are late for an appointment we will not provide service for more than 10 minutes past your originally scheduled session's end time. This enables us to remain punctual through out the day.

24 HOUR Cancellation Policy
In fairness to other clients and to our therapists we request that you cancel any scheduled appointment with at least a 24 hour notice. Sessions cancelled with less than 24 hours notice will be billed the full price of the massage.

If I am an 8WW client, at the discretion of the office, I may lose the appointment.

I also agree to adhere to the center's policies on tardiness and inclement weather.

Client Signature:_____Date:_____

CHIROPRACTIC PATIENTS: COMPLETE ONLY NAME AND D.O.B. OTHER INFORMATION IS ON FILE.

Client Information

Name_____ Phone (_____)_____ DOB _____

Address _____ City_____ State _____ Zip _____

E-mail: _____

Referred by:_____ Phone (_____)_____

In case of emergency:_____ Phone (_____)_____

Occupation_____ ❑ Male ❑ Female

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ❑ Yes ❑ No How recently?_____

What are your massage or bodywork goals?_____

What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Are you wearing contact lenses?
❑ Yes ❑ No Are you wearing dentures?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No Are you taking high blood pressure medication?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you suffer from joint swelling?
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have any contagious diseases?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies?

❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Any broken bones in the past two years?
❑ Yes ❑ No Any injuries in the past two years?
❑ Yes ❑ No Do you have tension or soreness in a specific area?
Please specify _____
_____
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you suffer from back pain?
❑ Yes ❑ No Do you have numbness or stabbing pains?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery? Explain below.
❑ Yes ❑ No Other medical condition, or are you taking any medications I should know about?

Comments _____
_____

Client Signature_____ Date_____

Practitioner Signature_____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize_____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian_____ Date _____

KSC-37-1115