Larmour Chiropractic, Inc.

10515 West Drive♦Fairfax, VA 22030♦Phone: 703-503-5033 ♦ Fax: 703-503-5037

Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Nick Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑ Samoan ❑ Guamanian or Chamorro ❑ Other ❑ I choose not to specify

_____

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued …

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Verification Question *(choose only one question by circling the question, then give the answer to that question)*

- ❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
- ❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
- ❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

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How long have you had this condition?_____

What do you think caused this condition?_____

Is this condition: □Improved □Unchanged □Getting Worse

Have you had similar conditions in the past? □Yes □No

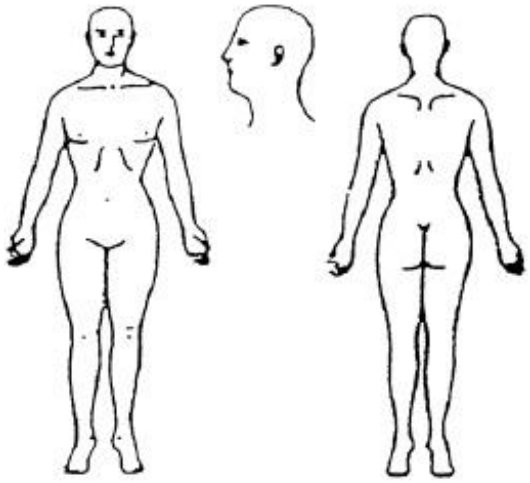
What makes it feel worse?(i.e. positions/movement/activities)_____

_____

What makes it feel better?(i.e. positions/meds/activities)_____

_____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:
Aches ^^^^ Numbness oooo Pins/Needles ···· Stabbing ////



MARK AN "X" ON THE LINES:

How bad are your symptoms now?

_____
None Most Severe

How bad have they been in the past?

_____
None Most Severe

I authorize the doctor, and whom he may designate as his assistants to administer the appropriate diagnostic and therapeutic procedures as are considered necessary on the basis of findings during the course of my examination and treatment.

Signature_____ Date_____

Parent of Guardian _____Date_____

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Name:_____ Date:_____

Please circle current conditions and any former conditions.

Musculo-Skeletal
Headache
Neck/shoulder/arm pain
Back pain
Low back/ leg pain
Arthritis
Nervousness/irritability/tension
Stiff neck
Back ache
Swollen joints
Tremors
Painful tail bone
Foot Trouble
Pain between shoulders
Hernia
Spinal Curvature (Scoliosis)
Faulty posture

General Symptoms
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in arms, Hands, or legs
Allergy
Neuralgia

Gastrointestinal
Poor appetite
Excessive Hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids
Liver Trouble
Gall bladder trouble
Jaundice
Colitis
Diritculosis

Cardio-Vascular
Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Previous heart attack
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke

Skin
Skin eruptions
Itching
Bruises easily
Dryness
Boils
Various veins
Sensitive Skin
Hives or allergy
Shingles

Gentourinary
Frequent urination
Painful urination
blood in urine
Puss in urine
Kidney infections
Bed wetting
Inability to control urine
Prostate trouble
Bladder infection

Respiratory
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing
Asthma

Distorted Senses
Sight
Hearing
Touch
Taste
Smell
Eye pain
Earache
Ear noises
Sore throat

Female
Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Congested brest
lumps in breast
Menopausal symptoms

Check any of the following diseases you have previously had or currently have:

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet	Fever	Diabetes	Venereal Infection
Diphtheria	Whooping	Cancer	Arthritis
Typhoid	Anemia	Heart Attack	Epilepsy
Pneumonia	Measles	Goiter	Mental disorders
Rheumatic	Mumps	Influenza	Lumbago

Family History

Does anyone in your family suffer from the same or similar malady as you? Y N
Who?_____
Does anyone in your family suffer from cancer? Y N
Who?_____
Does anyone in your family suffer from diabetes? Y N
Who?_____

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Our Policy Regarding Insurance

You have requested that our office accept *insurance assignment* on your case to assist you in meeting your financial obligation for your treatment. We offer this option of payment to our patients as a courtesy, and, as such, our patients must understand and agree to the following stipulations:

1. Insurance assignment begins after all of the forms that we need have been completed. Until this occurs, you are required to pay for all services in full.

2. Your insurance policy is an agreement between you and your insurance company; therefore, you are ultimately responsible for the payment of any and all services rendered.

3. Your deductible must be met in this office before co-payments can be accepted.

4. You must pay all co-payments and non-covered charges at the end of each visit.

5. If you discontinue care at any time for any reason, you total account balance is due and payable immediately. If and when your insurance company sends us monies for services you have paid for, the monies will be forwarded to you.

6. Your insurance company may pend charges at any time. If this happens, as a courtesy to you we will contact the insurance company for the reason of the pending. If they do not cover the charges pending, you will be responsible for payment of those charges within ten (10) days of notification.

7. This office can only verify of your insurance has chiropractic benefits. Our verification does not guarantee that the carrier will pay for all of the charges. You are ultimately responsible for payment of all services rendered in this office.

8. You agree that if you fail to pay any amount due on your account, you will pay interest at a rate of six percent (6%) per month. You also agree to pay all costs of collection, including $500.00 plus 1/3 of the amount due at time of default for attorneys' fees, court costs and a Fifty Dollar ($50.00) charge for returned checks.

We ask that you sign this for as an acknowledgment that our policy was explained to you and that you accept full responsibility for all services rendered.

Thank you.

_____ _____

Patient Signature Date

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ACKNOWLEGDMENT
OF
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES.

I, _____, hereby acknowledge that I have received a copy of Larmour Chiropractic, Inc.'s NOTICE OF HEALTH INFORMATION PRIVACY PRACTIVES and have chosen:

□ to read the notice and understand how my medical information may be uses and disclosed.

□ not to read the notice, but understand that I may receive a copy of the notice if I request to do so in the future.

_____
Signature Of Patient

___/__/_____
Date of Signature

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Larmour Chiropractic, Inc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request that we restrict how we use and disclose your protected health information for the purposed of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Signature Date

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Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have hac an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does no: necessarily indicate an error n judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have reac, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ Patient's Name (Print)

_____ Patient's Signature

_____ Date

_____ Relationship or authority if not signed By patient

_____ Witness

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INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The ìteamî approach has the best chance of attaining y our goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of ìcontrolled strainî, there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

_____ DATE_____

SIGNATURE OF PARTICIPANT

_____ DATE_____

SIGNATURE OF WITNESS