CONFIDENTIAL
HEALTH INFORMATION

Columbia Pike Chiropractic
Jaime A. Chica D.C

Today's Date: _____ Chart Number:_____

Personal Information

First Name: _____ Middle:_____Last:_____

Address:_____ Apt: _____

City:_____ State_____ Zip:_____ Date of Birth:_____

Home Phone: ( )_____-_____ Social Security Number :_____

Cell Phone: ( )_____-_____ Gender: ☐ Male ☐ Female

Fax Number: ( )_____-_____ Marital Status: ☐ Married ☐ Single ☐ Divorced

Email Address: _____ ☐ Separated ☐ Widowed

Spouse's name if married: _____ Ages of children: _____

How did you hear about us? ☐ Outdoor Sign ☐ Yellow Pages ☐ Medical Physician ☐ Insurance ☐ Lawyer ☐ Online

☐ Family/Friend ☐ Other:_____

Employer

Business name: _____ Occupation:_____

Business Address: _____City_____ State:_____Zip:_____

Phone: ( )_____-_____ Fax Number: ( )_____-_____ Type of work: _____

Emergency Contact:

Name: _____ Relationship:_____ Phone Number: ( )_____-_____

Who is responsible for your bill? ☐ Self (Paying Cash) ☐ Self (Health Insurance) ☐ Medicare

☐ Auto Ins ☐ Worker's Comp ☐ Other:_____

Insurance Carrier: _____ **Who carries this policy?**

Health ID Card No: _____ ☐ Self ☐ Spouse ☐ Parent

Group No:_____

Insured Person's Name: _____ Insured Person's Birth date: _____

Primary Care Physician: _____ Phone Number: ( )_____-_____

Car Accident Insurance Information:

Date of Accident: _____ Where did accident occur? _____

Which Best Describes You: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Name of your Car Insurance: _____ Claim #_____

Name of Other Party's Car Insurance: _____Claim #_____

Do you have a Lawyer? ☐ Yes ☐ No Name of Lawyer: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Pike Chiropractic or insurance company to release any information required to process my claims.

X _____ _____

Patient/Guardian Signature Date

CLINICAL HISTORY

Name: _____ Date: _____

☐ Automobile Accident ☐ Work Accident D.O.A: _____

CHIEF COMPLAINT

Pain Location: ☐ Head ☐ Neck ☐ Middle back ☐ Low back ☐ Chest ☐ Ribs ☐ R. Shoulder ☐ L. Shoulder ☐ R. Hand / Wrist. ☐ L. Hand / Wrist ☐ R. Knee. ☐ L. Knee ☐ R. Ankle / Foot. ☐ L. Ankle / Foot. ☐ Abdomen. ☐ Jaw

Explain:_____

_____

_____

Frequency: ☐ Constant. ☐ Occasional. ☐ Intermittent ☐ Frequent.

Pain Description: ☐ Achy ☐ Sharp ☐ Burning ☐ Dull ☐ Pounding. ☐ Stabbing ☐ Stiffness ☐ Radiating Leg / Arm L/R

Pain Progression: ☐ Same ☐ Getting Worst ☐ Improving ☐ Fluctuating

Severity: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

-------Mild ------ -------Moderate------- -------Severe-------

Additional Symptoms: ☐ Dizziness ☐ Nausea ☐ Anxiety ☐ Loss of smell ☐ Irritability ☐ Depression ☐ Confusion ☐ Arm numbness / tingling R or L? ☐ Pain behind eyes ☐ Breathing difficulties ☐ Sleeping difficulties ☐ Loss of taste ☐ Blurred vision ☐ Concentration difficulties ☐ Ringing ears ☐ Leg numbness / tingling R or L?

FAMILY HISTORY

Mark with an X if anybody on your family (parents, relatives) suffer of any of the following illness:

Cancer	☐	Epilepsy	☐	Arthritis	☐	Kidney disease	☐
Tuberculosis	☐	Dementhia	☐	Hemophilia	☐	High Blood Pressure	☐
Diabetes	☐	Gout	☐	Asthma	☐	Heart Disease	☐

PERSONAL HISTORY

Surgeries :☐ (Describe) _____

Hospitalization: ☐ (Describe)_____

Medications that you are currently taking :_____

_____

Auto Accident : Yes ☐ No ☐ When?: _____

Allergies: Yes ☐ No ☐ Smoke?: Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

Drink alcoholic beverages? Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

GENERAL

Mark the most appropriate:

	Past	Present		Past	Present
Headaches	☐	☐	Work Injury	☐	☐
Hemophilia	☐	☐	Venereal disease	☐	☐
Psychiatric problems	☐	☐	Eating disorders	☐	☐
Thyroid Disease	☐	☐	Drug dependency	☐	☐
Depression	☐	☐	Dizziness	☐	☐

	Past	Present		Past	Present		Past	Present		Past	Present
Asthma	☐	☐	Cancer	☐	☐	Arthritis	☐	☐	Anemia	☐	☐
Epilepsy	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐
Fever	☐	☐	Gout	☐	☐	Aids	☐	☐	Vitamins	☐	☐

SKIN

Psoriasis	☐	☐	Eczema	☐	☐	Dermatitis	☐	☐	Herpes	☐	☐

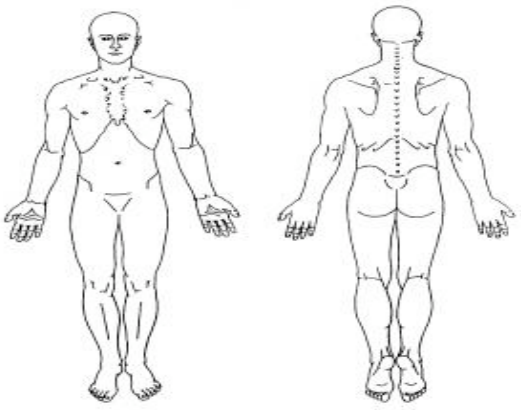
CLINICAL HISTORY

EENT	Past	Present		Past	Present		Past	Present
Glaucoma	☐	☐	Visual impairment	☐	☐	Otitis	☐	☐
Cataracts	☐	☐	Tinitus	☐	☐	Sinusitis	☐	☐
Conjuntivitis	☐	☐	Loss of Hearing	☐	☐	Nose Bleeding	☐	☐
Rhinitis	☐	☐	Persistent Cough	☐	☐	Hoarseness	☐	☐

CARDIOVASCULAR - RESPIRATORY	Past	Present	GASTROINTESTINAL - G / U	Past	Present
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Chest Pain	☐	☐	Ulcer	☐	☐
Myocardial Infarction	☐	☐	Loss of Apetite	☐	☐
Heart Disease	☐	☐	Flatulence (gas)	☐	☐
Rheumatic Fever	☐	☐	Vomit, Nausea	☐	☐
Heart Murmur	☐	☐	Abdominal Pain	☐	☐
Ankle Swelling	☐	☐	Gall Bladder Stones	☐	☐
Difficulty breathing, walking, sleeping	☐	☐	Hemorrhoids	☐	☐
Chronic Cough	☐	☐	Constipation	☐	☐
Spitting Phlegm	☐	☐	Hernia	☐	☐
Spitting blood	☐	☐	Jaundice	☐	☐
Pneumonia	☐	☐	Kidney Stone	☐	☐
Bronchitis	☐	☐	Urinary Tract Infection	☐	☐
			Blood in Urine	☐	☐
			Difficulty Urinating	☐	☐

REPRODUCTIVE	Past	Present
Pregnant	☐	☐
Irregular Menses	☐	☐
Abnormal Pap	☐	☐
Prostate Problem	☐	☐
Testicular Pain	☐	☐

Mark with an X the places of pain



MUSCULOSKELETAL AND NERVOUS SYSTEM	Past	Present
Low Back Pain	☐	☐
Neck Pain	☐	☐
Pain between Shoulder Blades	☐	☐
Pain in Arms	☐	☐
Pain in Legs - Sciatica	☐	☐
Muscle Cramps	☐	☐
Loss of strength in arms or legs	☐	☐
Numbness arms or legs	☐	☐
Loss of sensation arm or leg	☐	☐
Herniated Disc-Spine	☐	☐
Scoliosis	☐	☐
Fractures - Sprains	☐	☐
Osteoporosis	☐	☐
Short Leg	☐	☐

Prior Similar Symptoms

☐ I have not had any symptoms similar to my actual condition
☐ I had my actual symptoms before, but they didn't bother me
☐ My actual symptoms already existed but they got worse after the accident
My most recent symptoms (if applicable) occurred: _____ ☐ months ago
_____ ☐ years ago or on Date: _____/_____/_____

Signature: _____ Date: _____

Columbia Pike Chiropractic

Jaime A. Chica D.C.

5555 Columbia Pike, Suite #201, Arlington, VA 22204
Phone: (703) 379-6300 Fax: (703) 379-4440

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANFING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME SERVICE IS REQUIRED.

If this account is assigned to an attorney/or outside agency for collection and/or suit, Columbia Pike Chiropractic shall be entitled to reasonable attorney's fees and for cost collection.

I authorize the release of any information necessary to determine the liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT SIGNATURE INSURED'S SIGNATURE

_____

DATE

INSURANCE ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Columbia Pike Chiropractic to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance.

AUTHORIZATION TO PAY BENEFITS:
I hereby authorize my insurance carrier(s) to make payment directly to Columbia Pike Chiropractic for the Chiropractic and/or medical benefits payable for the services rendered.

_____ _____

PATIENT SIGNATURE INSURED'S SIGNATURE

_____

DATE

Columbia Pike Chiropractic

Jaime A. Chica D.C.

5555 Columbia Pike, Suite #201, Arlington, VA 22204
Phone: (703) 379-6300 Fax: (703) 379-4440

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of you PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law
(c) Is required to abide by the terms of the Privacy Notice
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
(e) Will distribute any revised Privacy Notice to you prior to implementation
(f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 9/23/2013

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of the Notice, and my understanding and my agreement to its terms

_____
PATIENT

_____
DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of the Notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other

Details:

_____ _____
Signature of Practice Date

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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 (s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

COLUMBIA PIKE CHIROPRACTIC

5555 COLUMBIA PIKE STE 201 ARLINGTON, VA 22204-3117

(703) 379-6300

Print name (s) doctor (s) treating this patient:

Jaime Chica D.C.