Fairfax Station Chiropractic

New Patient Intake Form

How were you referred to us? _____ **Date:** _____

Patient Demographic Information

Name: _____ _____

last *first* *name you would like to be called*

Address: _____ **Sex: M / F**

_____ **Age:** _____

Date of Birth: _____

Email: _____ **SSN:** _____

Home#: _____ **Cell#:** _____ **Work#:** _____

Employer: _____ **Employer Address:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Home#: _____ **Cell#:** _____ **Work#:** _____

Insurance Information

Name of Insurance Company: _____

Name of Insured: _____ **Relationship to Patient:** _____

Assignment and Release

I. **I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Christopher C. Virusky and Fairfax Station Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered.**

II. **I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance claims.**

III. **I understand and agree that I will be financially responsible for any and all actual collection costs that are incurred which could be as much as 50% of the unpaid balance should my account become delinquent and is referred to a collection agency or attorney.**

IV. **I understand and agree that any delinquent account will accrue interest at 1.5% per month or 18% per annum.**

Signature of Insured _____ **Patient Signature** _____

Patient Health History

Please circle any health conditions that apply:

AIDS-HIV	Bleeding Disorder	Cancer	Diabetes	Epilepsy/Seizures	Pinched Nerve
Arthritis	High Blood Pressure	Stroke	Heart Disease	Kidney Disease	Thyroid Problems
Hepatitis	High Cholesterol	Hernia	Herniated Disc	Tumor/Growth	Osteoporosis
Migraines	Prostate Problems	Fractures	Pacemaker	Liver Disease	Suicidal Thoughts
Headaches	Low Back Pain	Neck Pain	Depression	Allergies: _____	
				_____	

***Are you pregnant?** **Yes** **No**

Please list any medications, vitamins and supplements. Include dose and side effects, if any.

_____

_____

Exercise Level: (Circle the one that applies) None / Moderate / Daily / Heavy

Work Activity: (Circle all that apply) Sitting / Standing / Light Labor / Heavy Labor

Social History: (Circle all that apply) Smoking / Alcohol / Coffee / Caffeine / High Stress

Reason for Visit

Please describe your chief complaint: _____

When did your symptoms first appear: _____

Was the onset of symptoms: Gradual / Sudden (circle one)

Is the condition getting progressively worse? Yes / No (circle one)

How often is your complaint present: Constant / Frequent / Occasional / Intermittent / Rare

Is it better in the: Morning / Evening / Midday Is it worse in the: Morning / Evening / Midday

Does it interfere with your: Work / Sleep / Daily Routine / Child Care / Other _____

How intense is your pain: (Circle number)

0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

No pain Moderate pain Severe pain

Circle the activities that are painful or difficult to perform:

Coughing/sneezing	Getting out of a car	Turning over in bed
Walking short distance	Bending forward to brush teeth	Standing for more than 1 hr.
Sitting at a table/desk	Lying on back	Lying flat on stomach
Lying on side w/bent knees	Bending over forward	Reaching
Sexual activity		

What makes your condition better: (circle all that apply)

Nothing / Standing / Walking / Sitting / Movement / Exercise / Medication / Inactivity / Sleep
Lying Down / Hot Shower-Bath / Stretching / Other_____

What makes your condition worse: (circle all that apply)

Nothing / Lifting / Trying to Stand / Standing / Walking / Sitting / Movement / Exercise / Inactivity / Work Activities / Home Activities / Other_____

What treatment have you already received for this condition? (Circle answers that apply)

Medication / Surgery / Physical Therapy / Chiropractic / Massage / Other_____

Name of other physicians who have treated you for this condition: _____

_____

Date of last:

X-ray: _____ Results: _____

Spinal Exam: _____ Results: _____

MRI: _____ Results: _____

Cat Scan: _____ Results: _____

Bone Density Scan: _____ Results: _____

Surgical History: _____

Family History: _____

Trauma History (car accident, etc.): _____

Primary Care Physician: Name: _____

Ph: _____ Fax: _____

Address: _____

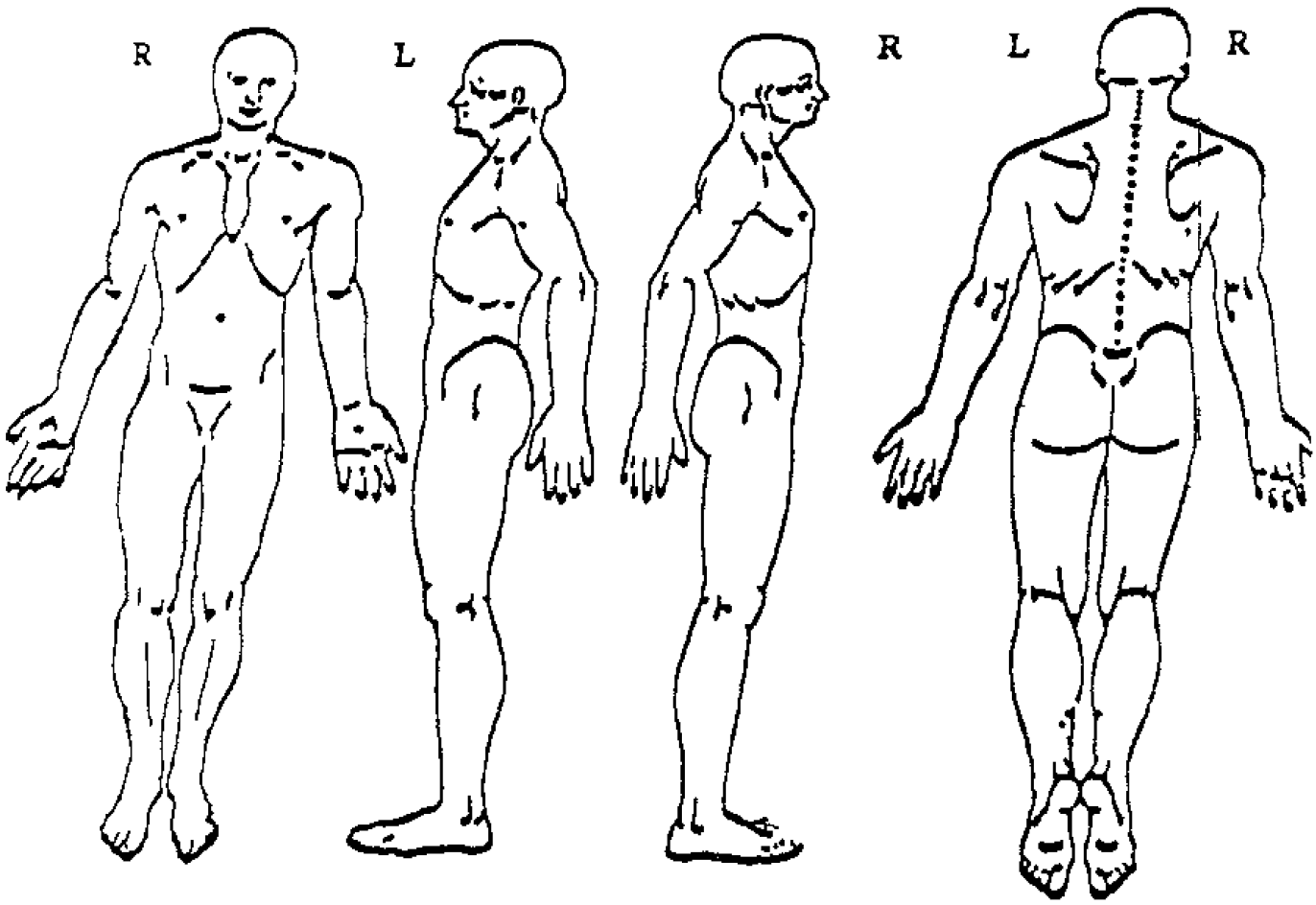
_____

Pain Drawing

Mark the location of your pain on the bodies below using the following letters:

A = ache B = burning N = numbness P = pins/needles S = stabbing

O = other (please specify) _____



Neck Index

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index

Back Index

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it does not increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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Appointment Cancellation & Missed Visit Policy

We understand that life can be unpredictable and schedules may change. Our goal is to provide each patient with dedicated time and attentive care, and we appreciate your help in allowing us to serve all patients efficiently.

Our office reserves dedicated treatment time, therapy space, equipment, and staffing for each scheduled appointment. To help us continue providing high-quality, individualized care and appointment availability for all patients, **we require at least 24 hours' notice for appointment cancellations or schedule changes.**

Appointments canceled with **less than 24 hours' notice** will incur a **$30 late cancellation fee.**

Same-day cancellations and missed appointments will be charged the full self-pay visit **amount of $82.50.**

We understand that emergencies and unavoidable situations may occasionally arise, and the office reserves the right to make exceptions when appropriate.

By signing below, you acknowledge that you have read, understand, and agree to this cancellation and missed appointment policy.

Patient Name: _____

Signature: _____ Date: _____

Thank you!
We appreciate the opportunity to serve you.

Fairfax Station Chiropractic

Acknowledgment of Receipt of Notice of Privacy Practices
Financial Policy and Informed Consent

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that as the patient, I am ultimately financially responsible for all chiropractic services rendered. I also understand that unless other arrangements have been made, payment, including appropriate co-payments is due at the time of service. Christopher C. Virusky, D.C. and Fairfax Station Chiropractic participates in many insurance plans, and will call to verify benefits. I understand that the benefits quoted by my insurance company is not a guarantee of payment, and that I am responsible for any non-covered services, deductibles or co-payments.

If I am presenting myself as a worker's compensation or personal injury case, I understand I will have additional information to provide to Christopher C. Virusky, D.C. and Fairfax Station Chiropractic, included, but not limited to, the name of the insurance carrier, claim number, and date of accident. I further understand that I may become personally responsible for payment in full if my claim is denied.

We understand there is sometimes a need to cancel or reschedule an appointment. Please give us the courtesy of a phone call if something prevents you from making your appointment time. We reserve the right to charge a fee for no-shows, or cancellations without 24 hours notice.

As a patient of Christopher C. Virusky, D.C., and Fairfax Station Chiropractic, I have been informed of the possible risks and complications of chiropractic care. I understand that most complications are mild and can include muscle tightness or soreness after a chiropractic adjustment. I also understand that there is a risk of more severe complications, including stroke or death. My signature below indicates that I have reported my medical history, current medications, and trauma history to the best of my knowledge, and that I give my consent for chiropractic treatment to be performed by Christopher C. Virusky, D.C. at Fairfax Station Chiropractic.

Patient signature _____ Date _____

Name(Print) _____