Kline chiropractic & Wellness
4004 Genesee Place Suite 213 • Woodbridge, VA 22192 • p: 703-680-4344 • f: 703-680-0440

PATIENT INFORMATION *(Please print)*

Name _____ Date _____

Address _____ City _____ State_____ Zip _____

Birth Date_____ Age_____

Home Phone _____

Work Phone_____

Cell Phone _____

Email Address:

_____

(*Circle one*) Male Female Minor Married Divorced Widowed Single Separated Employer

_____ Occupation _____

Business Address_____ City _____ State _____ Zip_____

Spouse's or Parent's Name_____

Emergency Contact_____ Phone_____

SYMPTOMS

Reason for visit _____ When did they symptoms start? _____

How did the symptoms start?_____

Where specifically are the symptoms located?_____

Is the pain getting worse with time? **Yes** **No** What makes the symptoms better? _____

What makes the condition worse? _____

For the following check all the appropriate descriptions for your symptoms:

☐ Constant ☐ Comes and Goes ☐ Infrequent ☐ Sharp ☐ Dull ☐ Aching ☐ Shooting
☐ Cramping ☐ Tingling ☐ Shooting ☐ Numbness ☐ Stiffness ☐ Swelling

Is the pain: ☐ Worse in the AM ☐ Worse in the PM ☐ Worse while sleeping ☐ Worse with activity

Is the pain: ☐ Better with activity ☐ Better with rest ☐ Better with medication

Does the pain travel (radiate): ☐ NO ☐ YES If YES, where? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Rate the severity of your pain (1 is mild, 10 is excruciating pain) circle one: 1 2 3 4 5 6 7 8 9 10

What treatment have you already tried? Medication _____

Physical therapy _____ Surgery_____ Other _____

What other doctors have you seen for this condition?

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HEALTH HISTORY (Circle only those that apply)

AIDS/HIV	Anemia	Abdominal surgery	Arthritis	Bleeding Disorder
Cancer	Depression	Diabetes	Epilepsy	Fibromyalgia
Irregular Heart Beat	Hepatitis	Osteoporosis	Pacemaker	
Prostrate Problems	Prosthesis	Stroke	Thyroid Problems	

Other _____

(Women only) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List all medications you are taking: _____

Do you smoke? Yes No _____ packs per day. How much alcohol do you drink per week? _____

How many caffeinated beverages do you drink per day? _____

How often do you exercise? _____What type of exercise? _____

What is your stress level? _____

List any significant injuries or traumas you have had in the past: _____

_____

ASSIGNMENT AND RELEASE

I certify that I have read and understand the above information. The above questions have been accurately answered. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Kline Chiropractic & Wellness, PLLC any insurance benefits otherwise payable to me. I understand that I am responsible for all charges. If the doctor is a participating provider for my insurance, I understand that I am responsible for any co payments, deductibles, or other charges in accordance with my plan. I authorize the use of this signature on all insurance submissions. Patient accounts with balances over 30 days old are charged and annual interest rate of 12% (1% monthly).

Signature of patient (or parent) _____ **Date**

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Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open-door" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open-door" adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provides the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Written Communication

_____ OK to mail to my home address
_____ OK to mail to my work/office address
_____ OK to fax to this number _____

Telephone Communication

Home Telephone
_____ OK to leave a message with detailed information
_____ Leave a message with call-back number only

Work Telephone
_____ OK to leave a message with detailed information
_____ Leave a message with call-back number only

Cell Phone
_____ OK to leave a message with detailed information
_____ Leave a message with call-back number only

NOTE: Uses and disclosures of PHI may be permitted without prior consent in an emergency.

Signature: _____ Date:_____

Printed Name: _____