NOVA SPINE & SPORTS REHAB

e: info@ novaspineandsports.com
p: 703-942-8828
f: 703-942-8829

8206 Leesburg Pike, Suite 309
Vienna VA 22182

PATIENT INFORMATION

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Sex: □ Male □ Female Age:_____

Date of Birth: ____/____/_____

Phone #: Home- _____

Cell- _____

Work- _____

Email: _____@_____._____

Employer: _____

Occupation: _____

How did you hear about us? :

_____

Have you ever been to a chiropractor before?: □ yes □ no

Primary Doctor: _____

Phone: _____

EMERGENCY CONTACT:

Name: _____

Phone: _____

INSURANCE INFORMATION

Insurance Co: _____

Policy ID#: _____

Group #: _____

Subscriber's name: _____

Relationship to patient:
□ Self □ Spouse □ Child □ Other: _____

Subscriber Date of Birth: ____/____/_____

Subscriber Address: _____

City: _____

State: _____ Zip: _____

Is there a secondary health insurance?:
□ yes □ no If yes, please list: _____

Is this related to auto or work injury?: □ yes □ no

Please allow our staff to photocopy your driver's license and insurance card. All information is confidential.

HIPAA INFORMATION

I have read and understood the "Notice of Privacy Practices" for NoVa Spine and Sports Rehab Corp. I understand that if I have any questions regarding this policy I may ask the doctor.

I authorize the office to contact me at:
□ home □ work □cell
We may leave message at:
□ home □ work □ cell.

Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

I (_____) hereby instruct and direct my insurance company (_____) to pay by check or electronic funds transfer (EFT) made out to **NoVa Spine and Sports Rehab Corp.** For the professional or medical expense benefits allowed and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment. (1: a photocopy of this assignment shall be considered as effective and valid as the original; 2: I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case; 3: I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf) I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered as per the financial policy. A copy of this financial policy will be furnished on request.

Signature: _____ Date: _____

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► What is your **current complaint**?:

_____

_____

_____

► My current complaint is a result of _____

► When was the **onset** of this problem?: _____ ☐ gradual ☐ sudden

► Since the onset, has the problem been getting **better, getting worse,** or **not changing**?: _____

► How frequently does this bother you?: ☐ constant (76-100% of the day) ☐ frequent (51-75% of the day) ☐ occasional (26-50% of the day) ☐ intermittent (0-25% of the day)

► On a scale of 0-10, (with 10 being the most painful and 0 being no pain at all), how would you **rate your pain**?

0 (no pain) 1 2 3 4 **5** (moderate pain) 6 7 8 9 **10** (severe pain)

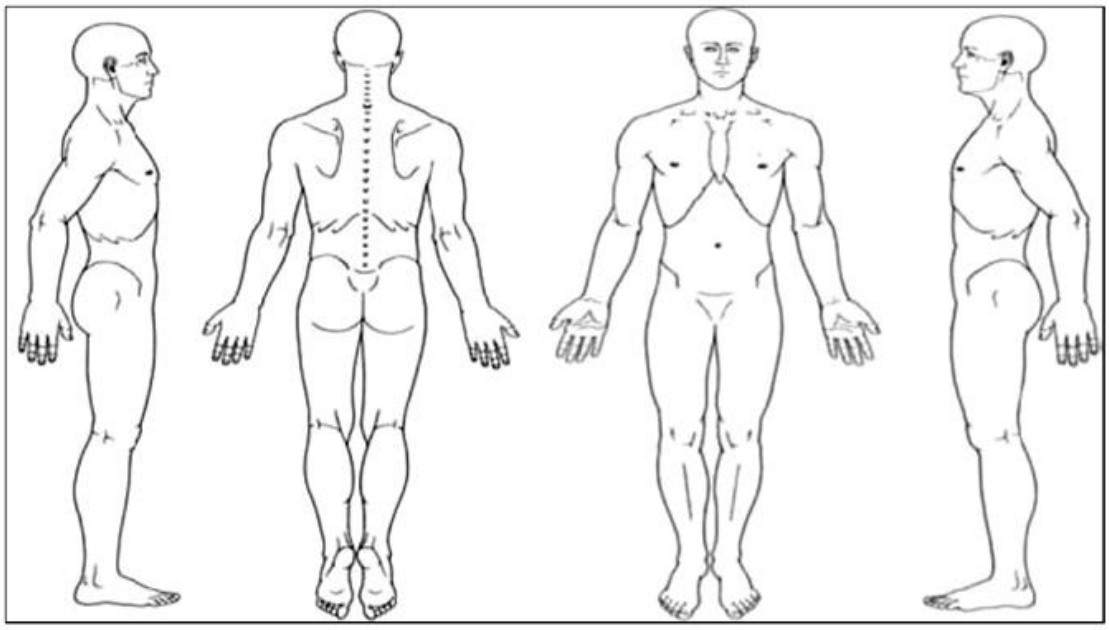
► How would you describe the **quality** of the symptoms you are experiencing?:

☐ numbness ☐ tingling ☐ stiffness ☐ dull ☐ aching ☐ cramping ☐ other: _____

☐ nagging ☐ sharp ☐ burning ☐ shooting ☐ throbbing ☐ stabbing

► Radiation: does it affect other areas of your body? If so, where does it radiate? _____

► Location: please mark the body diagram where you are experiencing your current symptoms, using the appropriate symbols.



^^^	Aches
OOO	Numbness
☐☐☐	Pins/Needles
XXX	Burning
///	Stabbing

► **Aggravating factors**: what tends to worsen the problem or increase pain?: _____

► **Relieving factors**: what tends to lessen the problem or decrease pain?: _____

► Have you had **any other treatment** for this complaint?: ☐ yes ☐ no

If yes, please check which treatment:

☐ prescription medication ☐ OTC drugs ☐ homeopathic remedies ☐ massage

☐ physical therapy ☐ surgery ☐ acupuncture ☐ chiropractic

► Is the problem worse at a certain **time of day**?: ☐ morning ☐ midday ☐ night ☐ comes and goes

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Employment, Activities of Daily Living, and Recreation Information:

► Description of work: _____

► Condition's effect on work: ☐ no effect (no pain, can perform) ☐ mild effect (painful, can do) ☐ moderate (painful, limited ability) ☐ severe (painful, cannot perform)

Daily Activities: Effects of Current Condition on Performance

► Place an (X) in the box of those that apply:

	No effect	Mild (painful, can do)	Moderate (painful, limited)	Severe (cannot perform)
Bending				
Self care				
Carrying Groceries				
Sitting to Standing				
Climbing Stairs				
Driving				
Extended Computer Use				
Feeding				
Household Chores				
Kneeling				
Lift Children				
Lifting				
Pet Care				
Reading				
Bathing				
Dressing				
Shaving				
Sleeping				
Sitting				
Standing				
Walking				
Yard work				

► **Medical Conditions**: check all that apply to you

□ arthritis	□ cancer	□ diabetes	□ heart disease	□ hypertension	□ psychiatric illness
□ skin disorder	□ stroke	□ headaches	□ multiple sclerosis	□ epilepsy	□ gout
□ hepatitis	□ HIV/AIDS	□ tuberculosis	□ GI problems	□ ulcer	□ immune disorders
□ osteoporosis	□ scoliosis	□ neck pain	□ back pain	□ hip pain	□ knee pain
□ foot pain	□ shoulder pain	□ TMJ pain	□ anxiety	□ depression	□ blood disorder
□ dizziness	□ numbness	□ bruising	□ high cholesterol	□ asthma	□ emphysema
□ pneumonia	□ blurred vision	□ hearing loss	□ aortic aneurysm	□ eczema	□ low energy
□ kidney stones	□ fainting	□ fatigue	□ sudden weight change	□ psoriasis	

□ other: _____

► **Surgeries**: please list all surgeries and hospitalizations ☐ spine ☐ pacemaker ☐ other:

_____

_____

► **Injuries**: please list any significant traumas or accidents you have had in your lifetime

_____

_____

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► **Allergies**: please list any allergies you may have, and your reaction to the allergen

_____
_____

► **Social History**: check all that apply to you

Caffeine Use:	☐ daily	☐ weekly	☐ occasionally	☐ never
Alcohol Use:	☐ daily	☐ weekly	☐ occasionally	☐ never
Tobacco Use:	☐ daily	☐ weekly	☐ occasionally	☐ never
Exercise:	☐ daily	☐ weekly	☐ occasionally	☐ never
Pain Relievers:	☐ daily	☐ weekly	☐ occasionally	☐ never

► **Family History**: check all that apply

☐ Arthritis ☐ Diabetes ☐ Heart disease ☐ Thyroid ☐ Depression ☐ Multiple Sclerosis
☐ Cancer ☐ Stroke ☐ Hypertension ☐ Autoimmune ☐ Other: _____

► **Medications/Supplements**: please list all medications or supplements you currently take, and the reason for taking them.

_____
_____
_____
_____

► **Imaging**: have you had any recent x-rays, MRI's, or CT scans?: ☐ yes ☐ no if yes, of what? _____

► Are there any other personal health or hereditary issues NoVa Spine & Sports Rehab should know about?

_____
_____

► What **specific goals** would you like to accomplish with chiropractic treatment? (i.e. walking / running without pain, sitting comfortably, do your job without pain, etc..)

_____
_____

Acknowledgements

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of care in this office.

_____ I acknowledge that any insurance I may have in an agreement between the carrier and me that I am responsible for the payment of any covered or non-covered services I receive.

_____ I understand there is a 24 hour no show/cancellation policy and I will be charged $30 if I don't provide proper notice of cancellation via email/voice mail/office call.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

If patient is a **minor**, print child's full name: _____

_____ _____

Patient Signature **Date** (MM/DD/YYYY)