Commonwealth Chiropractic Center of Reston
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Reston, Virginia 20190
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WWW.CCCRESTON.COM
RonaldS.Kulik,D.C.
NeilP.McLaughli,D.C.

COMMONWEALTH CHIROPRACTIC & WELLNESS

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Gender
◯ Male ◯ Female

Your Last Name

Birth Date (MM/DD/YYYY)

Your First Name | Your Middle Name (or Initial)

Marital Status
◯ Single ◯ Married ◯ Divorced
◯ Widowed ◯ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

May we share your health information with your emergency contact? ◯ Yes ◯ No

Child's Name and Age

Have you consulted a chiropractor before?
◯ No ◯ Yes When? _____ If so, whom? _____

Your Occupation

Your Employer

May we contact you at work?
◯ Yes ◯ No

Address

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Patient name

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ 10
Absent Uncomfortable Agonizing

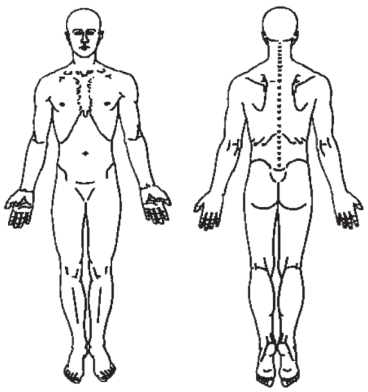
5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other _____

7. Location (Where does it hurt?)
Circle the area (s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication	◯ Surgery	◯ Ice
◯ Over-the-counter drugs	◯ Acupuncture	◯ Heat
◯ Homeopathic remedies	◯ Chiropractic	Other _____
◯ Physical therapy	◯ Massage	_____

11. What else should Commonwealth Chiropractic Center know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household resposibilities: _____

Personal relationships: _____

13. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

Consultation Notes

Doctor's Initials

Ronald S. Kulik, D.C.
Neil P. McLaughlin, D.C.

14. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy

NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms

NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight change	○	○	Weakness

NONE ○ Initials ____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

15. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer _____			
○	○	Chicken pox _____			
○	○	Diabetes _____			
○	○	Epilepsy _____			
○	○	Glaucoma _____			
○	○	Goiter _____			
○	○	Gout _____			
○	○	Heart disease _____			
○	○	Hepatitis			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

16. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

17. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter): _____

18. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Patient name

○ All other systems negative

Consultation Notes

Doctor's Initials

Ronald S. Kulik, D.C.
Neil P. McLaughlin, D.C.

19. Family History
Some health issues are hereditary. Tell Commonwealth Chiropractic Center about the health of your immediate family members.

Patient name

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

20. Are there any other hereditary health issues that you know about? _____

_____

21. Social History
Tell Commonwealth Chiropractic Center about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			
Hobbies: _____						

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Consultation Notes

29. Preferred Language: _____

Smoking Status:
- ○ Every Day Smoker
- ○ Occasional Smoker
- ○ Former Smoker
- ○ Never Smoked
- ○ Decline to Answer

Race:
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ White (Caucasian)
- ○ Native Hawaiian or Pacific Islander
- ○ Other
- ○ Decline to Answer

Height: _____ ft _____ in

Weight: _____ lbs

Blood Pressure: _____ / _____

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Decline to Answer

Preferred method of communication for patient reminders:
- ○ Email
- ○ Phone

By signing below you confirm that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity or cause of your health concern.

PATIENT'S NAME (PLEASE PRINT) _____

Signature of the patient or parent/guardian _____ Date _____

Doctor's Initials

Ronald S. Kulik, D.C.
Neil P. McLaughlin, D.C.

Office Policy

1. **Chiropractic Care** – You instruct the chiropractor to deliver the care that in his professional judgment can best help you in the restoration of your health. You understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
2. **Insurance** – You hereby assign all medical benefits to which you are entitled to Commonwealth Chiropractic Center of Reston in the event they file insurance claims on your behalf and authorize said assignee to release all information necessary to the appropriate authorities to secure the payment of said benefits. You understand that you are financially responsible for all and any charges covered or non-covered by your insurance in the event your account becomes delinquent. You accept responsibility for the principal amount owed as well as all reasonable costs associated with collection of this debt. This includes but is not limited to collections fees, attorney's fees and all court costs and additional legal fees. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balance over 30 days. You must pay all deductibles in full and your co-payment must be paid at the time of service or at the end of each week.
3. **Payments** – Commonwealth Chiropractic Center of Reston is committed to providing a range of payment options to meet your financial obligation. Due to the continued rising cost of credit and debit card processing and security fees all credit and debit card transactions will incur a 3.75% surcharge. CCC of Reston does not receive any portion of the surcharge. If a refund is requested via credit or debit card the base amount of the transaction will be refunded 100%, but the surcharge fee will be retained by the third party processor. Our office will continue to accept payments by means of checks and cash, free of any surcharge. Please note if your check is returned for insufficient funds there is a $35.00 fee per returned check.
4. **Appointments** – Commonwealth Chiropractic Center of Reston allocates specific time for your appointments to meet the needs of your treatment program. If you are unable to keep your appointment, we require that you contact us as soon as possible to reschedule your visit. It is your obligation to make up a missed appointment within 7 days of any cancellation. We reserve the right to charge $45.00 for each missed appointment and those cancelled without 24 hours' notice.
5. **Communication** – You agree to be sent text and email messages to confirm or reschedule an appointment, as well as occasional cards, letters, or emails as an extension of your care in this office. You understand that unencrypted email and texts may not be secure and that standard text messages/data rates from your mobile carrier may apply to the messages sent. You may opt-out of receiving these communications at any time by letting CCC of Reston know in person, by calling the office at 703-742-7856, or by replying "STOP" to one of the messages.
6. **HIPAA** – You may request a copy of the Privacy Policy and understand it describes how your personal health information is protected and released on your behalf to other healthcare professionals involved in your care or for seeking reimbursement from any involved third parties.
7. **For Women Only** – You realize that and x-ray examination may be hazardous to an unborn child and certify that to the best of your knowledge you are not pregnant.
   Date of your last menstrual period (MM/DD/YYYY): _____ Please initial here: _____
8. **For Parents/Guardians of Minor Patients Only** – You hereby authorize Dr. Ronald S. Kulik and /or Dr. Neil P. McLaughlin to examine, perform any medically necessary tests or x-rays, and treat your child (please write your child's full name) _____. This consent to treatment will be considered valid until Commonwealth Chiropractic Center of Reston is notified in writing by a parent/guardian.

By signing below you acknowledge that you have read, fully understand and accept full financial responsibility, and that you irrevocably agree to the policies established by this office. A copy of this assignment shall be considered as effective and valid as the original.

PATIENT'S NAME (PLEASE PRINT) _____

Signature of the patient or parent/guardian _____ Date _____