Commonwealth Chiropractic Center of Reston
11495 Sunset Hills Road Ste 240
Reston, Virginia 20190
703 - 742 - 7856
WWW.CCCRESTON.COM
Ronald S. Kulik, D.C.
Neil P. McLaughlin, D.C.

Commonwealth Chiropractic Center
Reston

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 Social Security Number

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

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

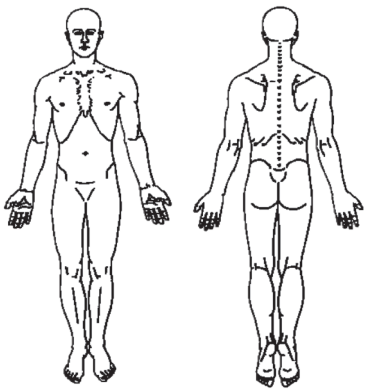
5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____

_____

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

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

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? _____

_____

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.

Initials ____ **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. I also 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.**

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

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment.**

Initials ____ **I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

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

Initials ____ **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 the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Consultation Notes

Patient name _____

Doctor's Initials _____

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INSURANCE ASSIGNMENT POLICY

I hereby assign all medical benefits to which I am entitled to Commonwealth Chiropractic Center of Reston in the event they file insurance claims on my behalf. I hereby authorize said assignee to release all information necessary to the appropriate authorities to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I agree that all charges that are not directly paid by my insurance company _____ in accordance with the participation guidelines of my policy will be my responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance in the event my account becomes delinquent and is therefore in default of payment. I accept responsibility for the principal amount owed as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service 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 balances 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. There is a $20.00 fee for all returned checks.

APPOINTMENT POLICY

Commonwealth Chiropractic Center allocates specific time for your appointments to meet the needs of your treatment program. Therefore, if you are unable to keep your appointment, we require that you call 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 $40.00 for each missed appointment and those cancelled without 24 hours' notice. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment.

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.

_____

PATIENT'S NAME (PLEASE PRINT)

_____ _____

Signature of the patient or parent/guardian Date

CONSENT TO TREATMENT (FOR MINOR PATIENTS ONLY)

I hereby authorize Dr. Ronald S. Kulik and/or Dr. Neil P. McLaughlin to examine, perform any medically necessary tests or x-rays, and treat my daughter / son _____ .

PATIENT'S NAME (PLEASE PRINT)

This consent to treatment will be considered valid until Commonwealth Chiropractic Center of Reston is notified in writing by a parent/guardian. A photocopy of this consent form shall be as effective as the original when so presented.

_____ _____

Signature of the patient or parent/guardian Date

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STATEMENT OF PRIVACY PRACTICES
HIPAA GUIDELINES COMPLIANCE

Commonwealth Chiropractic Center follows the Health information Portability and Accountability Act (HIPAA), passed into law in 1996. HIPAA sets federal standards for privacy and security of patient information for all healthcare providers, insurance companies, and anyone they do business with. Our goal as chiropractic health care providers is to deliver quality treatment and care while protecting both the privacy rights of our patients and their confidential information that they have entrusted to us. It is the commitment of this office and all its employees to ensure that this health information is not compromised. Our privacy policies apply to all former, current and future patients so you can be assured that your health information will never be improperly disclosed or released. Any changes or modifications of our privacy policies and practices will be posted at the front desk. Complete copy of "Summary of the HIPAA Privacy Rule" is available for your review or at www.hhs.gov/ocr/hipaa.

USES AND DISCLOSURES OF HEALTH INFORMATION

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Except as stated in more detail in the "Summary of the HIPAA Privacy Rule", we will not use or disclose your health information without your written authorization. However, in the following circumstances, we may use or disclose your health information without your written authorization:

- to family members and/or caregivers involved in your health care;
- for certain limited research purposes;
- for purposes of public health and safety;
- to government agencies for purposes of their audits, investigations, and other oversight activities;
- to government authorities to prevent child abuse or domestic violence;
- to the FDA to report product defects or incidents;
- to law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- when required by court orders, search warrants, subpoenas, and as otherwise required by law.

PATIENT'S RIGHTS

As our patient, you have the following rights:

- to have access to and/or a copy of your health information;
- to receive an accounting of certain disclosures we have made of your health information;
- to request restrictions as how your health information is used or disclosed;
- to request that we communicate with you in confidence;
- to request that we amend your health information;
- to receive notice of our privacy practices.

If you have questions, concerns or complaints regarding our privacy practices, or if you believe your rights have been violated, please notify us immediately in writing. You can also notify the U.S. Department of Health and Human Services (http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html).

Please let us know if you have any questions concerning your privacy rights or the confidentiality of your health information as related in this document.

Sincerely,

The Doctors and Staff at Commonwealth Chiropractic Center of Reston

PLEASE KEEP THIS DOCUMENT