Maple Chiropractic & Acupuncture Clinic, LLC

10721 Main Street, Suite # 2500
Fairfax, VA 22030

PATIENT INFORMATION **Date ___/___/____**

Name_____Date of Birth ___/___/___ Age ____ Male/Female

Address_____ Apt # _____

City_____ State _____ Zip Code _____ Home Phone _____

Cell Phone _____ E-mail_____ SSN _____

Occupation_____ Employer's Name _____Work Phone_____

Work Address_____ City _____ State _____ Zip Code _____

Single _____ Married _____ Divorced _____ Separated_____Widowed _____ Minor _____

Emergency Contact _____ Relationship _____ Phone _____

Are you Pregnant? Yes ____ No ____ If yes, when is the due date? _____

Whom may we thank for referring you to us? _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to Patient_____

Insured/Subscriber Name _____ Insurance Company_____

Group number _____ Identification number _____

Address_____

Does patient have secondary insurance? Yes ___ No ___ If yes. please answer the following questions.

Insured/ Subscribe Name _____ Insurance Company _____

Group number _____ Identification number _____

Address _____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes ___ No ___ (if no continue to authorizations section)

Type of accident Auto ___ Work ___ Other ___

Have you made a report of your accident to anyone? Yes ___ No ___

If yes to whom: Auto Insurance ___ Employer ___ Worker Comp. ___ Police ___ Other ___

Did you have any accident/injury in the past? Yes ___ No ___ If yes, please briefly describe those and tell us how you took care of those injuries? _____
_____
_____
_____

Do you have an attorney? Yes___ No ___ If yes, Attorney's name _____

Attorney's Phone number _____

Authorizations

1) I hereby authorize Maple Chiropractic & Acupuncture Clinic, LLC to use my medical information and any other necessary information to process this claim and request payment of insurance benefits for the purpose of obtaining payment for the services rendered.
2) I understand and agree that health and accident policies are an arrangement between me and an insurance company. Also, I understand this office will prepare customary forms and reports so that I may obtain insurance benefit and any amount that authorized to be paid directly to this office will be credited to my account upon receipt. I also understand and agree that all services rendered to me are charged directly to me and I am personally responsible for my account.
3) I understand and agree that if I suspend or terminate my appointment of treatment as prescribed by the doctor in this office, any fees for professional services and products rendered will be due and payable immediately.

_____ _____

Signature of Patient (or Guardian if patient is a minor) Date

Patient Condition

Describe reason for today's visit _____

When did your symptoms appear? _____ What did cause it?_____

If accident caused your pain/injury, Date of the accident _____

Please briefly describe the accident _____
_____
_____

How is your condition now? Same ____ Better ____ Worse ____

If your pain is due to a car accident:

Were you Driver ____ Front seat Passenger ____ Right rear seat passenger ____

Middle rear seat passenger ____ Left rear seat passenger ____ Other _____

At the time of accident your vehicle was: Stopped ____ In motion ____

Did you have your seat belt on? Yes ___ No ___

Where did your vehicle struck from? Rear ___ Right side ___ Left side ___ Front ___ Other ___

At the time of accident you were looking: To the right ___ To the left ___ Straight forward ___ Other _

At the time of accident you were thrown: Forward ___ Backward ___ side to side ___ and hit _____
_____

Did you lose your consciousness after the accident? yes _____ No _____

Did the accident cause any cuts or bruises in your body? No ___ Yes ___ if yes, please briefly describe them:
_____
_____

Did you go to the hospital or Emergency room after the accident? Yes ___ No ___ If yes, please provide hospital's name and briefly describe what they did for you in the hospital: _____
_____
_____
_____

Have you seen another doctor for your condition? Yes ____ No ____ If yes, please provide

Doctor's name _____ Phone number _____

Pain Diagram

Patient Name _____ Date _____

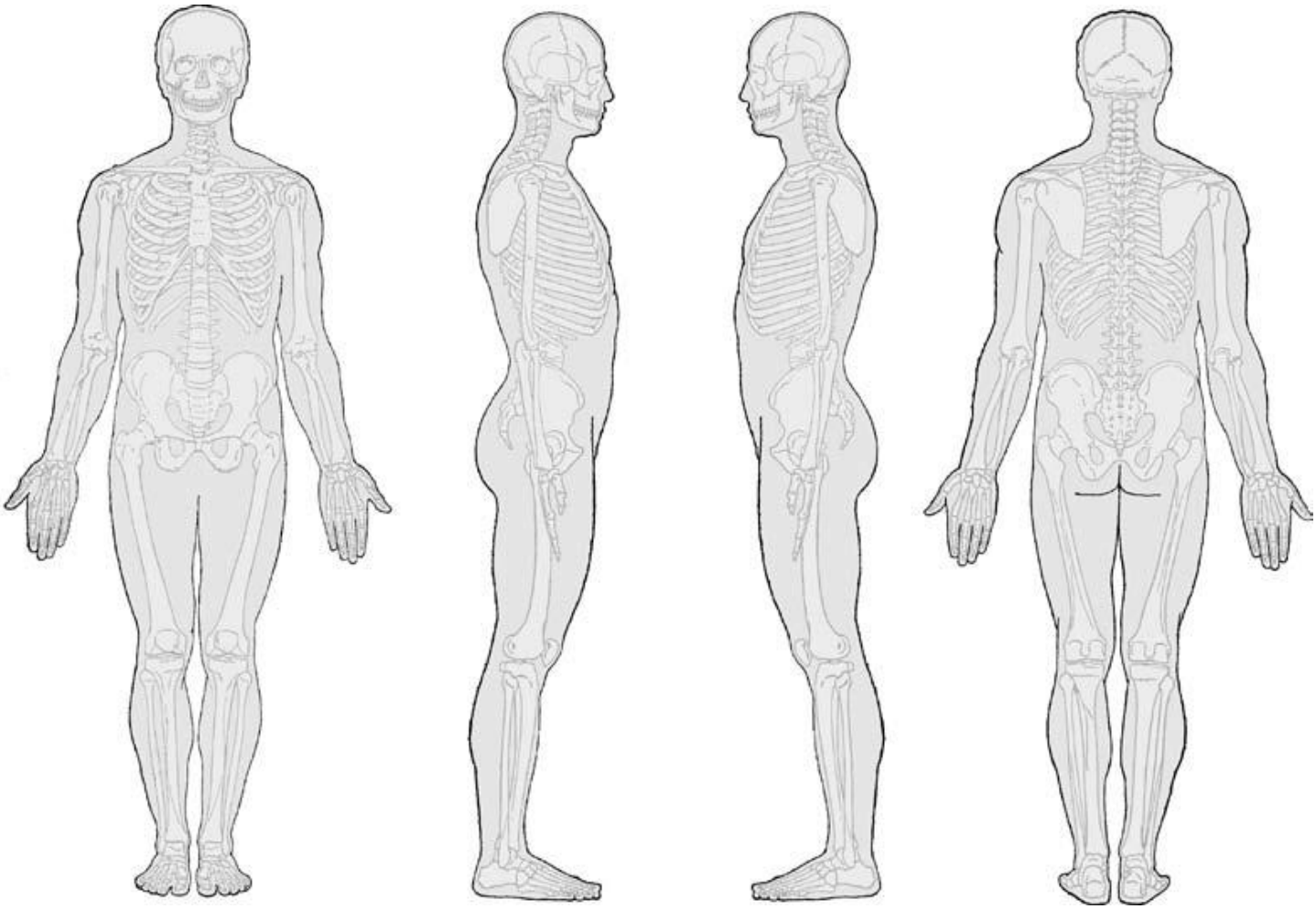
Mark the diagram below to indicate where you have pain or other symptoms. Please use the following symbols:

Aching = A, Burning = B, Sharp/Stabbing = S, Traveling/Shooting = TS, Numbness/Tingling = N,

Tightness = T, Pins and Needles = P, Other = O (Please describe) _____
_____

How severe is your pain? 0____1 ____2 ____3 ____4 ____ 5____ 6 ____ 7 ____ 8 ____9 ____10 ___
(no pain) (max. pain)

Please mark you area(s) of pain on the figure below



What makes your pain better? Rest __ Heat __ Ice __ Sitting __ Standing __ Lying down __Walking __
Massage __ Stretching __ Medication __ Nothing __ Other _____

What makes your pain worse? Breathing __ Bowel movement __ Coughing __ Driving __ Bending __
Exercising __ Sitting __ Standing __ Lying down __ Walking __
Lifting __ Turning __ Other _____

Past Health History

Please mark on yes or no and if it is yes, briefly explain:
Do you have any allergies? No ____Yes, _____
Have you been hospitalized in the past 5 years? No ____Yes, _____
Have you had any surgeries? No ____Yes, _____
Have you had any broken bones? No ____Yes, _____
Have you had any mental disorder? No ____Yes, _____

Please mark all conditions that you have now or had in the past:

AIDS/HIV	____	Emphysema	____	Kidney Disease	____	Scarlet Fever	____
Alcoholism	____	Epilepsy	____	Liver Disease	____	Sexually Transmitted Disease	_
Anemia	____	Glaucoma	____	Measles	____	Stroke	____
Anorexia	____	Goiter	____	Migraine Headache	__	Suicide Attempt	____
Appendicitis	____	Gout	____	Mononucleosis	____	Thyroid Problem	___
Arthritis	____	Growths	____	Multiple Sclerosis	__	Tonsillitis	____
Asthma	____	Heart Disease	____	Mumps	____	Tuberculosis	____
Bleeding Disorder	____	Hepatitis	____	Osteoporosis	____	Tumors, Growth	____
Breast Lump	____	Hernia	____	Parkinson's Disease	__	Typhoid Fever	____
Bronchitis	____	Herniated		Pinched Nerve	____	Ulcers	____
Bulimia	____	Disk	____	Pneumonia	____	Vaginal Infection	___
Cancer	____	High Blood		Polio	____	Whooping Cough	___
Cataracts	____	Pressure	____	Prostate problem	___	Other	_____
Chicken Pox	____	High		Rheumatoid		_____	
Diabetes	____	Cholesterol	____	Arthritis	____	_____	

What medication/supplement do you take? _____
_____
_____

What type of exercise do you do and how often? _____
_____

Do you drink alcohol? No ___ Yes ___ If yes, how often? _____

Do you smoke? No ____ Yes ____ If yes, how much? _____

When was your last physical exam? _____

Family History

Please indicate if any blood relatives has had any of the following conditions:

Arthritis ___ Cancer ___ Diabetes ___ Heart disease ___ High Blood Pressure ___ High Cholesterol__

Stroke ___ Neurological Disorder ___ Other _____

Signature: _____ Date: _____

Maple Chiropractic & Acupuncture Clinic, LLC
10721 Main St. Suite # 2500
Fairfax, VA 22033
703-657-0202

Informed Consent For Chiropractic Care

I, the undersigned, a patient in Maple Chiropractic & Acupuncture Clinic, LLC, hereby authorized this office to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

Every method of treatment or procedure in health care has some risks associated with it. Symptoms you may feel after starting chiropractic care include soreness, muscle strains, bruising, compression of peripheral nerve, nausea and dizziness. These symptoms may last 1-3 days. Severe risks such as nerve injury, fracture, dislocations, disc injuries and stroke are very rare but can occur.

I hereby certify that I have disclosed any and all necessary health and personal information that pertains to treatment I am seeking attention for in order for this office to make as accurate and appropriate diagnosis as possibly. I have included any and all relevant diagnostic testing and imaging as it pertains to my overall health.

The doctor has responded to all of my requests for information about proposed treatment. I have read, or have had read to me, this consent. I have also had the opportunity to ask questions about its content. By signing below I consent to treatment. I also certify that no guarantee of assurance has been made as to the results that may be obtained.

I hereby certify that I have read and understand the purpose of chiropractic care and the potential risk involved. Other treatment options have been explained to me and my questions about this consent form have been addressed.

I consent to receive the chiropractic care deemed necessary by the doctor.

Patient/ Guardian Signature: _____ Date: _____

Patient name (please print): _____

Guardian name (please print): _____

Relationship to Patient: _____